OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-777-374

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on June 23, 2009, in Denver, Colorado. The hearing was digitally recorded (reference: 6/23/09, Courtroom 4, beginning at 1:53 PM, and ending at 2:40 PM).

No attorney entered an appearance on behalf of the Claimant, and the Claimant did not appear at hearing. No attorney entered an appearance on behalf of the Respondent [Employer] and no representative appeared on behalf of [Employer].

ISSUES

The issues to be determined by this decision concern whether The Hartford provided workers' compensation insurance coverage to the Employer on November 16, 2008; and, whether Claimant and the Employer received legal notice of the June 23, 2009 hearing.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

Notice

1. On March 23, 2009, a Notice of Hearing was mailed, by the Office of Administrative Courts, to Oscar Delmar at 1910 Mount Sneffels Street, Longmont, Colorado 80501, his regular and last known address. Copies were also mailed to Respondent, The Hartford's, counsel at Hall & Evans, LLC.

2. On March 30, 2009, Hall & Evans, LLC, The Hartford's counsel, mailed the March 23, 2009 Notice of Hearing to the Claimant's last known address at 1910 Mount Sneffels Street, Longmont, Colorado 80501.

3. On March 30, 2009, Hall & Evans, LLC, mailed the Employer the March 23, 2009 Notice of Hearing to the Employer's last known address at 7601 Miller Drive, Frederick, Colorado 80504.

3. The U.S. Postal System did not return as undeliverable the correspondence enclosing the Notice of Hearing to either the Claimant or the Employer.

4. Megan E. Coulter, Esq. verified, as an officer of the tribunal, that she spoke with the former interim manager and Employer contact, Linda Rayne, regarding the date of the hearing. Additionally, Coulter verified that Rayne received notice of the April 30, 2009 Pre-Hearing Conference Notice at 7601 Miller Drive, Frederick, Colorado 80504, and appeared at the May 6, 2009 Pre-Hearing Conference. The Pre-hearing Conference notice contained the hearing date of June 23, 2009, the location and time of the hearing.

5. Megan E. Coulter, Esq. verified, as an officer of the tribunal, that she spoke with the Claimant's wife regarding the June 23, 2009 hearing. Coulter further verified that the Claimant's wife confirmed understanding of the time and date of the hearing.

6. There is no indication that any lawyer or law firm entered an appearance on behalf of the Claimant or the Employer before the date of the hearing on June 23, 2009.

Cancellation of Coverage

7. On or about November 16, 2008, Claimant allegedly sustained a workers' compensation injury. His right hand was caught in the machine and injured.

8. On November 18, 2008, the Employer filed an Employer's First Report of Injury, identifying The Hartford as the workers' compensation insurance carrier.

9. On November 25, 2008, The Hartford filed a Notice of Contest. The Notice of Contest denied Claimant's claim because The Hartford cancelled the Employer's workers' compensation insurance policy prior to November 16, 2008.

10. On December 9, 2008, Claimant filed an Application for Expedited Hearing and an Application for Hearing.

11. The Hartford continued to deny this claim because it did not provide workers' compensation insurance coverage to the Employer on the alleged date of injury.

12. On August 6, 2008, Respondent Hartford sent correspondence to the Employer via certified mail initiating cancellation for nonpayment of premium.

13. The August 6, 2008 correspondence notified the Employer that the workers' compensation insurance policy would be cancelled on August 22, 2008 for nonpayment of premium. If the Employer, however, could pay $4,201.20 before August

22, 2008, Hartford, as a matter of grace, provided that their workers' compensation coverage would continue without interruption.

14. Alice Smith testified on behalf of The Hartford. Smith is the Front Line Manager at The Hartford. She is in charge of all Direct Notices of Cancellation (DNOC) and Reinstatement Notices.

15. It is The Hartford's normal business custom to send DNOCs via certified mail to the insured, via regular mail to the broker or producer, and electronically file the DNOC with the Division of Workers' Compensation.

16. Smith's undisputed testimony was that the DNOC was sent certified mail to the Employer, via regular mail to Hill Insurance Services, LLC and was filed electronically with the Division of Workers' Compensation.

17. In addition to correspondence notifying the Employer that their workers' compensation policy would be cancelled, The Hartford also sent a "Notice of Cancellation" via certified mail on August 6, 2008, reflecting the workers' compensation policy would expire "effective at 12:01 a.m. on August 22, 2008 for nonpayment of premium. "

18. The Employer received the August 6, 2008 correspondence and Notice of Cancellation on August 9, 2008.

19. A copy of the correspondence to the Employer cancelling coverage and the Notice of Cancellation was sent via regular mail to the broker, Hill Insurance Services, LLC, on August 6, 2008.

20. On August 6, 2008, The Hartford filed a Notice of Cancellation electronically with the Colorado Division of Workers' Compensation. The Notice of Cancellation reflected that the Employer's workers' compensation insurance policy would be cancelled on August 22, 2008 for nonpayment of premium.

21. Hill Insurance Service, LLC received actual notice of the Notice of Cancellation sent by regular mail by The Hartford.

22. On September 3, 2008, the broker for Hill Insurance Services, LLC contacted The Hartford via telephone regarding the DNOC. The agent, Raquel Alessio, indicated she did not know the reason the "dnoc went unpaid."

23. On September 3, 2008, The Hartford sent an email to Alessio's email address at Hill Insurance Services, LLC, with a reinstatement offer.

24. The Hartford offered the Employer reinstatement of workers' compensation insurance coverage if the Employer paid $2,980.00, and signed an

attached No Loss Statement and Indemnity, on or before September 10, 2008. (*See* Respondent, The Hartford's, Ex. K, bates 065—068).

25. Smith testified that if the Employer paid the required amount of $2,980.00 on or before September 10, 2008, the Employer's workers' compensation coverage would be reinstated as of the date of cancellation on August 22, 2008.

26. The Hartford did not receive any payment from the Employer, or the signed No Loss Statement and Indemnity, on or before September 10, 2008.

27. On September 11, 2008, The Hartford closed the reinstatement offer.

28. Nothing in the circumstances of the cancellation of the Employer's coverage could lead the Employer to have a reasonable expectation that it was covered. The Employer simply did not pay the full premium and, after being given a generous and reasonable opportunity to reinstate after the cancellation, the Employer did nothing.

29. The Hartford did not provide workers' compensation insurance coverage to the Employer on November 16, 2008. Therefore, Respondent Hartford has proven, by a preponderance of the evidence that it provided no workers' compensation insurance coverage to the Employer on November 16, 2008. Therefore, the Employer was a non-insured Employer on that date.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Notice

a. Service of process mail is presumed to have been received by its addressee when there is proper evidence of its mailing to a named person at a correct address, with adequate prepaid postage. As found, all notices of the hearings established a legal presumption of receipt, warranting a finding of receipt by the Employer. *See Olsen v. Davidson,* 142 Colo. 205, 350 P. 2d 338 (1960). *See also Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993). As found, the March 23, 2009 Hearing Notice was sent to the Claimant's last known address and to Hall & Evans, LLC. The US Postal Service did not return the Hearing Notice as undeliverable. As found, Hall & Evans, LLC, sent the hearing notice via regular mail to the Claimant at his last known address. Additionally, Hall & Evans, LLC sent a copy of the March 23, 2009 notice to Mike Rosenthal at the Employer's last know address, on March 30, 2009. A copy of the Hearing Notice was not returned to Hall & Evans, LLC as undeliverable by

the US Postal Service. Consequently, it is presumed the Claimant and the Employer received copies of the March 23, 2009 Hearing Notice.

b. The concept of substantial compliance, however, has been applied to various notice requirements in workers' compensation proceedings even when those requirements otherwise appear to be mandatory. *EZ Building Components Mfg., LLC v. Industrial Claims Appeals Office and Summers*, 74 P.3d 516 (Colo. App. 2003).

c. A statute requiring notice by certified mail need not be strictly enforced if actual notice was received and the statute does not treat the method of notice as jurisdictional. *EZ Building Components Mfg., LLC v. Industrial Claims Appeals Office and Summers*, *supra*.

d. Whether notice is mailed is a question of fact. The existence of a business custom is sufficient to warrant a presumption that notice was sent, and it is the province of the trier of fact to decide whether that presumption has been overcome by other evidence. *EZ Building Components Mfg., LLC v. Industrial Claims Appeals Office and Summers*, *supra*.

Lack of Coverage

e. As found, The Hartford substantially complied with § 8-44-110, C.R.S. (2008), in providing Notice of Cancellation to the Employer and Hill Insurance Services, LLC. *EZ Building Components Mfg., LLC v. Industrial Claims Appeals Office and Summers*, *supra*. As found, The Hartford properly provided Notice of Cancellation on August 6, 2008 for nonpayment of premium to the Employer via certified mail, Hill Insurance Services, LLC via regular mail and electronically sent the Notice of Cancellation to the Division.

f. If a putative insured has a reasonable expectation of insurance coverage, *i.e.,* by paying the premiums expected within the time specified by the carrier, a technical glitch may not prevent "constructive" coverage. *See Sanchez v. Connecticut General Life Insurance Co.,* 681 P.2d 974 (Colo. App. 1984); *Rager v. Bainbridge, Inc.,* W.C. No. 3-825-303 (Industrial Claim Appeals Office, July 25, 1988). As found, nothing in the circumstances of the cancellation of the Employer's coverage could lead the Employer to have a reasonable expectation that it was covered. The Employer simply did not pay the full premium and, after being given a generous and reasonable opportunity to reinstate after the cancellation, the Employer did nothing. Consequently, there was **no** "constructive" coverage.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Claimant's claim for workers' compensation benefits against The Hartford in W.C. No. 4-777-374 is hereby denied and dismissed. The Employer stands as a non-insured employer, subject to concomitant penalties.

B. Any and all issues not determined herein, including the liability of the non-insured Employer herein, are reserved for future decision.

DATED this_____day of July 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-715-730

ISSUES

Whether Claimant has proven by a preponderance of the evidence that he has sustained functional impairment beyond the level of the arm that should be compensated as whole person impairment.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant is employed as a package car driver for Employer. On February 14, 2007 Claimant sustained an admitted injury as the result of a motor vehicle accident. On that date Claimant's package car was struck on the left side under the driver's seat by another vehicle that had run a red traffic light.

2. Following the injury Claimant initially received treatment at the emergency room at Parker Adventist Hospital. Claimant was then referred to Mile Hi Occupational Medicine and was evaluated on February 15, 2007 by Dr. Kerry Kamer, D.O.

3. On February 15, 2007 Claimant complained to Dr. Kamer of left shoulder discomfort, limited movement and exertion. On physical examination Dr. Kamer noted that Claimant's cervical active range of motion was normal and without discomfort. Dr. Kamer diagnosed a left acromino-clavicular joint separation.

4. Dr. Kamer referred Claimant to an orthopedic physician and Claimant was evaluated by Dr. Peter L. Weingarten on February 20, 2007. Dr. Weingarten noted that X-rays demonstrated a Grade III – IV AC separation. Dr. Weingarten scheduled Claimant for surgery for open reduction/internal fixation of the separation. Surgery was performed by Dr. Weingarten on February 23, 2007.

5. Following surgery Claimant came under the care of Dr. Matt Miller, M.D. at Mile Hi Occupational Medicine and Dr. Miller became Claimant's authorized treating physician.

6. Claimant was seen for follow up by Dr. Weingarten on July 3, 2007. Dr. Weingarten noted that Claimant's shoulder motion was full with no discomfort and excellent strength. Dr. Weingarten cleared Claimant for all activities.

7. Dr. Miller released Claimant to return to regular duties on July 5, 2007. On that date Claimant told Dr. Miller he would like to return to regular duties. On examination Dr. Miller noted minimal discomfort with palpation over the AC joint. Dr. Miller noted that Claimant had good range of motion in all planes with slight limitation of strength with external rotation.

8. Claimant reached maximum medical improvement on August 23, 2007. At that time Dr. Miller performed an impairment rating and evaluation. Dr. Miller's physical examination on that date was similar to the results of the examination on July 5, 2007. Dr. Miller assigned Claimant 4% impairment of the upper extremity based upon 2% impairment for loss of flexion, 1% impairment for loss of abduction and 1% impairment for loss of internal rotation.

9. Claimant underwent a DIME performed by Dr. Elizabeth Bisgard, M.D. on January 7, 2008. Dr. Bisgard agreed that Claimant reached maximum medical improvement on August 23, 2007 as assessed by Dr. Miller. Dr. Bisgard assigned Claimant 10% impairment of the upper extremity based upon 5% impairment for loss of flexion, 1% impairment for loss of extension and 4% impairment for loss of abduction.

10. Dr. Bisgard noted that Claimant had pain localized to the trapezuis causing discomfort over the shoulder girdle area. Dr. Bisgard opined, and it is found, that this discomfort did not alter Claimant's scapulothorcic motion, but was causing discomfort and limitations with glenohumeral motion above 90 degrees. The ALJ finds that this opinion and statement from Dr. Bisgard establishes that Claimant's trapezius discomfort was not causing a functional impairment above or proximal to the level of the glenohumeral joint.

11. Claimant continues to work as a package car driver for Employer although Claimant has subsequent to his return to work obtained an easier route in a newer vehicle. Claimant testified, and it is found, that his functional limitation is in raising his left arm.

12. The ALJ finds that while Claimant has symptoms of trapezius discomfort that is above the level of the arm or shoulder this discomfort principally affects the movement of Claimant's arm. Claimant does not have a functional impairment of his

scapulothoracic motion and the trapezius discomfort does not restrict Claimant's ability to use a portion of his body proximal to the arm at the shoulder. The ALJ interprets Dr. Bisgard's opinion that the trapezius discomfort causes limitation with glenohumeral motion above 90 degrees to refer to Claimant's ability to move his left arm above 90 degrees.

13. Respondents filed a Final Admission of Liability on February 14, 2008 admitting for the 10% upper extremity impairment assigned by Dr. Bisgard.

14. Claimant has failed to prove, by a preponderance of the evidence, that he has sustained functional impairment above the level of the arm at the shoulder.

CONCLUSIONS OF LAW

15. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

16. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

17. Section 8-42-107(1)(a), C.R.S. limits a claimant to a scheduled disability award if the claimant suffers an "injury or injuries" described in § 8-42-107(2), C.R.S. 2004. Strauch v. PSL Swedish Healthcare System, 917 P.2d 366 (Colo. App. 1996). The term "injury," as used in § 8-42-107(1)(a), refers to the situs of the functional impairment, meaning the part of the body that sustained the ultimate loss, and not necessarily the situs of the injury itself. Walker v. Jim Fuoco Motor Co., 942 P.2d 1390 (Colo. App. 1997). The term "injury" refers to the manifestation in a part or parts of the body that have been functionally impaired or disabled as a result of the industrial accident. *Warthen v. Indus. Claim Appeals Office,* 100 P.3d 581 (Colo. App. 2004). It is not the location of physical injury or the medical explanation for the "ultimate loss" which determines the issue. *Blei v. Tuscorora,* W.C. No. 4-588-628 (June 17, 2005)

18. Whether a claimant has suffered an impairment that can be fully compensated under the schedule of disabilities is a factual question for the ALJ, whose determination must be upheld if it is supported by substantial evidence.

Walker v. Jim Fuoco Motor Co.,supra. That determination is distinct from, and should not be confused with, the treating physician's rating of physical impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (rev. 3d ed.) (AMA Guides). Strauch v. PSL Swedish Healthcare System, supra; see also City Market, Inc. v. Indus. Claim Appeals Office, 68 P.3d 601, 603 (Colo. App. 2003)("The determination whether a claimant sustained a scheduled or nonscheduled injury is a question of fact or the ALJ, not the rating physician."). Kolar v. ICAO, 122 P.3d 1075 (Colo. App. 2005).

19. An injury involving the glenohumeral joint does not mandate conversion to whole person impairment. The fact that Claimant may have physical injury to structures found proximal to the arm does not compel a finding of functional impairment beyond the arm at the shoulder. Where the injury affected structures proximal to the arm and in the shoulder that resulted in functional impairment affecting the arm but did not extend beyond the shoulder the Claimant has failed to prove entitlement to whole person impairment. *Lovett v. Big Lots,* W.C. No. 4-657-285 (November 16, 2007), aff'd *Lovett v. Indus. Claim Appeals Office,* No. 07CA2375 (September 11, 2008) (not selected for publication).

20. In this case neither the authorized physician Dr. Miller, or the DIME physician Dr. Bisgard expressed specific opinions on the situs of the Claimant's functional impairment. Dr. Miller did not address this issue at the time he placed Claimant at maximum medical improvement and performed an impairment rating. Dr. Bisgard addresses the issue by noting Claimant's trapezius discomfort and expressing the opinion that it affected glenohumeral motion above 90 degrees but not scapulothoracic motion. In the absence of more definitive opinion or explanation, the ALJ must determine if this opinion establishes a functional impairment above the level of the arm and shoulder or if the functional impairment is primarily in the use of Claimant's left arm. As found, the ALJ concludes that Dr. Bisgard's opinion does not support a finding of functional impairment above the level of the arm. Dr. Bisgard although noting the discomfort in the trapezius did not opine that this discomfort functionally impaired Claimant's use of this muscle. As discussed above, that Claimant's injury has involvement in the glenohumeral joint does not compel conversion to whole person impairment. The involvement of the glenohumeral joint from Claimant's injury principally affects Claimant's movement and use of his left arm. Claimant has failed to prove that he has sustained a functional impairment to a part of his body proximal to or beyond the arm at the shoulder.

21. Claimant has sustained a 10% impairment of his left upper extremity as assessed by Dr. Bisgard.

ORDER

It is therefore ordered that:

That Claimant's claim for conversion to whole person impairment for his left shoulder injury of February 14, 2007 is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: July 1, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-404

ISSUES

The issues to be determined are whether the Claimant suffered a repetitive use occupational disease or aggravation to a pre-existing occupational disease, medical benefits, average weekly wage (AWW), temporary partial disability beginning August 5, 2008, and responsible for termination. The parties stipulated that Claimant's AWW is $742.11.

FINDINGS OF FACT

1. The Claimant has been employed by Employer in various clerical positions since June 1, 1990.

2. Prior to coming to work for Employer, Claimant suffered a compensable workers' compensation injury in 1989 with another employer that resulted in bilateral upper extremity and wrist problems with permanent work restrictions of no repetitive use of the upper extremities. Claimant was working as a data entry operator at the time of the injury. Claimant then sought employment in the secretarial field.

3. Claimant continued to have numbness and pain intermittently following the 1989 occupational injury.

4. Claimant suffers from various other non-work related disease processes including congestive heart failure, cardiomyopathy, obesity, irritable colon, hypertension, anticoagulation, which all caused various symptoms. As a result, Claimant requested, and Employer granted Claimant intermittent Family Medical Leave (FML) which allowed Claimant a reduction in the number of hours she worked each day.

5. On January 2, 2008, the Claimant was transferred to another division due to reorganization within her department. The transfer was a lateral transfer from one

Administrative Support Assistant III (ASA III) to another ASA III position without an increase or decrease in salary.

6. By her own admission, Claimant hated her job. Claimant did not want to work in the current division. From the beginning, she let it be known to the supervisory staff and her co-workers that she did not want to work there.

7. On Sunday, January 6, 2008, after having reported to work for two days, the Claimant obtained a medical statement from her private health care provider at Kaiser Permanente, Juventino Saavedra, M.D., who stated that Claimant had intermittent wrist tendonitis that became exacerbated with repetitive wrist movements, and requested an accommodation from using any office equipment that minimized repetitive strain on her wrists. Claimant presented the statement from Kaiser to her Supervisors on Monday, January 7, 2008.

8. Michelle Weiss-Samaras, Chief Deputy Coroner, who was sequestered during Claimant's testimony, credibly testified that after receiving the statement from Kaiser, she advised the Claimant that she did not have to use the hole punch. Claimant was told that she could ask her immediate Supervisor, Kathy Blea or one of her co-workers to do the hole punching. (Transcript p. 58, L. 12-22)

9. Claimant testified that she had to punch holes in 15 sheets of paper at one time and did this task five or six times each day. She further testified that she was required to file papers in binders weighing 25 pounds each. This testimony is not credible and is contradicted by Respondent's witnesses.

10. Claimant did not report the hole punching activities to health care providers. Claimant reported to Dr. Saavedra on January 8, 2008, that her job at the office required 80% typing mainly on a typewriter, and that her prior job required only 5% typing and it was on a computer. She also reported that she did more filing and noticed more wrist pain, but had not been using her wrist splints. (R. Ex. B. 112)

11. On cross-examination, Claimant initially denied that her supervisors allowed for the accommodation to not engaging in repetitive activities such as using the hole punch. Later she acknowledged that she was accommodated, but did not receive the electric hole punch that she requested. (Transcript. p. 32, L. 13-24) Claimant's attorney produced a three-hole punch at the hearing; however, admittedly, it was not like any utilized in the office. In rebuttal testimony, Claimant acknowledged that the three hole punches available for use in the office, all had a handle attached – including one that she claims to have used. (Claimant's rebuttal P. 7, L. 15 – 19) In Dr. Wunder's deposition, Respondent produced the three-hole punch that Ms. Blea testified was in use at the office. (picture of three-hole punch - Dr. Wunder's deposition transcript, Ex. 1). Although Claimant testified that she did not use the three-hole punch that was introduced during Dr. Wunder's deposition, she did agree that it was available to her.

12. Claimant's first line supervisor, Roberta "Kathy" Blea, credibly testified that during the first week Claimant worked at the Office, the Claimant primarily observed. Claimant did not engage in any typing activities on January 2nd, 3rd, or 4th, 2008. Ms. Blea was told by Ms. Weiss-Samaras that Claimant could not do hole punching. Ms. Blea also testified that typing was not 80% of Claimant's job. Ms. Blea described the ASA III duties as varied and that nothing required Claimant to be engaged in a sustained activity for a period of 20 minutes. Ms. Blea testified that contrary to Claimant's testimony that the binders weighed 25 pounds, the binders weighed probably five (5) pounds. Ms. Blea described the job duty of typing a death certificate as requiring approximately 54 – 58 key strokes. Ms. Blea was present during Claimant's rebuttal testimony and in surrebuttal, credibly testified consistent with her hearing testimony about the three-hole punch utilized in the office, stating that she did not recall seeing the three-hole punch Claimant described as being in the office.

13. Claimant's job as an ASA III in the office consists of varied task each day, including completing death certificates, which she averaged one per day, completing paperwork for the release of bodies to the mortuary, providing documents to the investigators for their files, answering the phones, responding to door buzzers, and releasing personal effects to the family of the deceased. Claimant did not do any one activity for a sustained period each day. (R. Ex. C 182- 188).

14. Claimant's work performance was poor throughout the year she worked in the office. On March 28, 2008, the Claimant had her first quarterly review. After having worked at the office for three months under a job classification that she had held for several years and seventeen years with the Respondent-Employer, the Claimant's work performance was in the opinion of her supervisors, as a new hire from the outside. Claimant made it clear that she did not like the job, did not want to be there, and her manner was abrupt. Claimant spent long periods preparing to get started working, or away from her desk without explanation. Claimant was on FML that allowed her to work a reduced number of hours each day, and while she was at work, she was unproductive which Claimant testified was correct. (R. Ex. C 182-188) Claimant was suspended from employment October 28 - 30, 2008, for poor performance (Transcript p. 37, L 14 – 16, R. Ex. C, B 163) and was given a verbal reprimand on September 15, 2008 for cumulative incidents of job neglect going back to March, 2008. (R. Ex. C, B 178).

15. In the March 14, 2008, Kaiser Permanente report from Michael Fisher, M.D. who was treating the Claimant for heart failure, the Claimant complained of "atypical symptom that she relates is intermittent numbness on the right side of her body, usually it has been one limb though recently she had one episode where the entire right side went numb". (R. Ex. B 100)

16. On April 23, 2008, Claimant was involved in a nonwork-related motor vehicle accident (MVA). Claimant was seen in the Emergency Department of Medical Center of Aurora with complaints of right hand, low back, neck, right foot, chest and abdomen injuries. Claimant reported that the accident involved right front area damage to the vehicle that received moderate damage from moderate velocity impact. She was

diagnosed with a neck strain, chest wall strain, abdominal wall strain, low back strain, right foot sprain and right hand sprain. (R. Ex. B 97, 97 A-G, 98)

17. On April 24, 2008, Claimant was seen at Swenson Chiropractic. Claimant complained of right upper extremity pain into hand, along with neck, headaches, upper back, middle back, and low back pain. Claimant also noted that she was experiencing left hand tingling and numbness because of the accident. (R. Ex. B 93 – 96).

18. On July 11, 2008, the Claimant was seen at Kaiser Permanente complaining of right hand numbness and pain radiating down the arm "worse on the right but occasionally has sx's of the left arm, feels a sensation like 'her body wants to shake' feels that her 'right side is numb' has bee diagnosed with carpel tunnel syndrome on the right". It was noted that Claimant "Was in MVA in 04/08, hit another car/fence, ever since has had back pain, reports the "whole body numbness' has been going on prior to the MVA". (R. Ex. B 88 - 91).

19. Simultaneously with treatment at Kaiser Permanente, Claimant continued to treat with Swenson Chiropractic for the April 23, 2008, MVA (R. Ex. B 80) when she filed an Employees Work Injury Report on July 29, 2008, alleging "tingling and numbness and sharp excruciating pain in my right hand, fingers, thumb, wrist, and arm, up to my shoulder. This pain is also starting to occur in the left hand". Claimant was treated at Swenson Chiropractic for both right and left wrist pain because of the April 23, 2008, MVA, both the day before, July 28, 2008, and the day after, July 30, 2008, filing the Employee Work Injury Report with the Respondent. (R. Ex. B 80).

20. The Claimant never informed her supervisors at the office that she had been in a MVA on April 23, 2008. When she reported the alleged work related injury, Employer offered the Claimant medical treatment through one of its designated providers, Concentra. Claimant was seen at Concentra on July 29, 2008. She provided a history that "my primary care doctor told me I have carpal tunnel syndrome and it is work related from repetitive motion". Claimant did not provide a history of the April 23, 2008, MVA, or disclose her treatment with Swenson Chiropractic. (R. Ex. B 81- 86).

21. Following the initial treatment at Concentra, the Claimant was given restrictions that Employer was willing to accommodate. However, Claimant rejected Employer's attempts to have her abide by the restrictions. Claimant's supervisor brought in an egg timer to help remind Claimant to take the 10 minute break every 30 minutes recommended by the authorized treating provider, but Claimant refused compliance stating "I'll see if you can enforce it, cause I am not going to". Claimant was belligerent when her supervisor advised Claimant that she was expected to comply with the restrictions – Claimant exclaimed "whatever".

22. Employer permitted Claimant to continue treating through Concentra while denying liability for the occupational injury reported on July 29, 2008. On August 26, 2008, the Claimant was scheduled for therapy appointment with Concentra. Prior to reaching the facility located at 3350 Peoria Street, Aurora, CO., the Claimant was

involved in a MVA in the 3100 block of N. Peoria Street. Claimant was at fault in the accident and charged with failure to yield the right of way when turning left in front of traffic. (R. Ex. D 207 – 214).

23. The Claimant was seen in the emergency department at University of Colorado Hospital Authority following the August 26, 2008, accident. The accident was described as a low impact collision in which the Claimant was the restrained driver traveling at a rate of between 5 – 15 mph the Claimant's vehicle was struck at the rear panel. The Claimant was assessed as having low back pain and upper chest pain with the "previous history of back injury from a different MVA." (R. B. Ex 70-77)

24. Claimant returned to Swenson Chiropractic on August 28, 2008, and continued treatment with additional complaints. Claimant was also seen by Dr. Griggs who ordered EMG/NCV testing to rule out carpel tunnel syndrome.

25. On September 5, 2008, Dr. Swenson authored a letter addressed to Richard Sandomire, Esq., regarding the April 23, 2008, MVA. Dr. Swenson's opinion was that with the "substantial injures" [sic] Claimant sustained in the April 23, 2008, accident, "exacerbations and remissions of the symptoms may recur later on, requiring future therapy and treatment at periodic intervals." Dr. Swenson stated that Claimant's prognosis is "guarded" and that Claimant has ligament instability at L4 on L5, "which is a permanent condition". (R. Ex. B 63-65)

26. On September 15, 2008, the Claimant was evaluated by Kathy McCranie, M.D. by referral from Dr. Griggs and Dr. Kohake, for a physiatric consultation and electrodiagnostic test. Claimant provided a history of onset of pain on February 11, 2008, in her right more than left hand and forearm that Claimant associated with typing and computer activities. The Claimant reported her prior work-related upper extremity injury and noted that she had permanent impairment as result of that injury. Claimant stated that in her current position, unlike the prior work injury with another employer, that she is "doing more varied activities where she was able to pacer [sic] herself to control those symptoms". (R. Ex. B 60 – 62).

27. During the September 15, 2008 evaluation of Claimant, Dr. McCranie conducted both an EMG study and Nerve Conduction study, and recorded her impression of the Claimant's condition as "borderline to very mild sensory median neuropathy, i.e. carpel tunnel syndrome and bilateral upper extremity pain and parasthesias". Dr. McCranie noted that the other carpal tunnel syndrome, testing for sensory and motor median nerves, were within normal limits. Dr. McCranie noted that there was no evidence of denervation in the median nerve distribution, cervical radiculopathy, brachial plexopathy, peripheral neuropathy, neurogenic thoracic outlet syndrome or ulnar neuropathy.

28. Claimant was evaluated by Jeffrey Wunder, M.D. on October 2, 2008. Claimant reported that "I hate the job". And, described her job duties of one hour of filing, and various other activities 50% of which are repetitive according to Claimant. Dr.

Wunder's impression of the Claimant's condition was mild bilateral de Quervain's tendinitis, possibly chronic, which Claimant stated that was "part of her original CTD diagnosis back in 1989". Dr. Wunder noted that Claimant's medical records indicate mild peripheral edema, which he states would contribute to median neuropathy at the wrists by increasing the carpel tunnel pressure without repetitive activity. Dr. Wunder is of the opinion that Claimant would not meet the criteria for work-related carpal tunnel syndrome under the Medical Treatment Guidelines based on the hours of repetitive activity. Dr. Wunder noted that significant in determining the causation issue is that Claimant has huge issues of job dissatisfaction. (R. Ex. B 55 – 57D).

29. Dr. Wunder persuasively testified that he would not expect Claimant to experience complaints only six days after starting the new job. Dr. Wunder also testified that hole punching, including 15 sheets at a time approximately 3 time each day and putting those documents in a three-ringed binder, along with typing on average 1 death certificate a day with up to 58 key strokes, did not constitutes high exertional force and repetition that would predispose the Claimant to carpal tunnel or exacerbate a preexisting cumulative trauma disorder or carpal tunnel syndrome. (Dr. Wunder deposition transcript p.10).

30. On November 11, 2008, Claimant was seen in the Emergency Department at Exempla St. Joseph Hospital with "multiple complaints including 6 – 8 mo of intermittent R sided numbness from head to toe, 3-4mo of bilat lower extrem cramping from pelvis to toes, and a few days ago having cramping and pains in hands and L side of neck. She's had episodes of lightheadedness, blurry vision and tiredness/fatigue. Says she has been walking a lot at new job x 6mo. which don't affect sx's but is more active than usual. She has been under a lot more stress. New glasses within this year. Sometimes gets nausea and pain after eating." Claimant was discharged home with a diagnosis of weakness and muscle cramps and a notation to consider connective tissue disease and to follow up with Claimant's primary care doctor for considering a referral to rheumatology for a connective tissue disease consultation. (R. Ex. B 35 – 47)

31. It is clear that Claimant did not want to work in the office, and that she made several attempts to have medical providers verify that her health would be better if she were in a different position. (R. Ex. B 27 – 28)

32. Claimant has failed to prove that her work at Employer's office was repetitive in nature and caused an aggravation of her pre-existing occupational disease.

33. Claimant has failed to prove that her work at Employer's office was repetitive in nature and caused an occupational disease to her upper extremities.

34. Claimant's testimony concerning her work activities and symptoms is not credible or persuasive.

CONCLUSIONS OF LAW

a.The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to the employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A Claimant in a workers’ compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101 C.R.S. A preponderance of the evidence is that which leads the Trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in the workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

b.The ALJ’s factual findings concern only evidence that is dispositive of the issues involved: the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

c. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 27 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

d. The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), C.R.S., as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

e. This section imposes additional proof requirements beyond those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). However, the existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers

from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

f. The claimant bears the burden to prove by a preponderance of the evidence that the hazards of the employment caused, intensified or aggravated the disease for which compensation is sought. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000); *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo. App. 1999). The question of whether the claimant has proven causation is one of fact for the ALJ. *Faulkner v. Industrial Claim Appeals Office, supra*. In this regard the mere occurrence of symptoms in the workplace does not require the conclusion that the conditions of the employment were the cause of the symptoms, or that such symptoms represent an aggravation of a preexisting condition. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (I.C.A.O. August 18, 2005). Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

g. The ALJ concludes that the Claimant has not met her burden of proof that her work for the Respondent caused an aggravation of her pre-existing occupational disease, nor has Claimant met her burden of proving that she sustained a new or separate occupational disease to her bilateral upper extremities that is causally connected to her employment with Respondent. Claimant's testimony is inconsistent with some of the medical records and contradicted by Employer's witnesses. Claimant's testimony is not credible or persuasive.

h. The "quasi-course of employment" doctrine provides that an injury occurring during travel to or from authorized medical treatment is compensable because the employer is required to provide medical treatment for the industrial injury and the claimant is required to submit to the treatment. *Excel v. Industrial Claim Appeals Office*, 860 P.2d 1393 (Colo. App. 1993). In *Jarosinski v. Industrial Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002), the Court held that "trips to receive authorized treatment constitute an implied condition or expectation of the employment contract. If the element of contractual obligation is missing, however, the resulting injuries are not compensable." *Id.* at 1085. The Judge concludes that Respondent was not contractually obligated to offer the Claimant medical care while contesting liability for the underlying bilateral upper extremity claim, and is therefore not liable for treatment of injuries stemming from the August 26, 2008 motor vehicle accident.

ORDER

It is therefore ordered that:

1. Claimant's claim is denied and dismissed.

DATED: July 2, 2009

Barbara S. Henk

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-719

ISSUES

- Did claimant prove by a preponderance of the evidence that he sustained an occupational disease type injury arising out of the course and scope of his employment?
- Did claimant prove by a preponderance of the evidence that he is entitled to medical and temporary disability benefits?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Employer operates a public transportation system. Claimant began working for employer as a probationary bus driver in June of 2008. Claimant's date of birth is October 14, 1946; his age at the time of hearing was 62 years. Because of intractable lower back pain, claimant has been unable to return to work at employer since Friday, September 26, 2008. Claimant contends he sustained an occupational disease arising out of a hazard of his employment because his back pain is unrelated to a discrete or acute work-related event. Employer contends that claimant's disability is a result of the natural progression of the underlying disease process in his lumbar spine.

2. Claimant has a rheumatoid arthritis disease process for which he has been receiving infusions of Remicade since 2002. Claimant also has diffuse, severe osteoporosis, osteopenia, and osteoarthritis. And claimant has chronic, 25-plus-year history of smoking cigarettes.

3. As a probationary driver, claimant was assigned various routes to drive. According to claimant, most of the driver's seats in the buses were out of adjustment and needed replacing. On August 22, 2008, claimant drove an AB Route, which involved 2 trips to Denver International Airport. The AB Route included numerous stops where claimant was required to help passengers load and unload luggage in the luggage compartment of the bus. Claimant stated that he had to help load some 70 to 80 pieces of luggage each direction on the AB Route. Claimant drove the AB Route to DIA a total of 6 shifts during his tenure as a driver for employer, including August 28th, September 5th, September 9th, September 11th, and September

12th. The Judge infers from the testimony of claimant and his wife that they believe that the activity of loading and unloading luggage on the AB Route was a hazard of claimant's employment that caused him to develop lower back pain. Claimant was unable to relate the development of his lower back pain to a discrete or acute incident or event at work.

4. On September 29, 2008, claimant sought medical attention from Christopher E. Ricca, M.D., for sinus congestion and worsening lower back pain. Claimant reported to Dr. Ricca that his back pain increased after riding his bicycle 3 days earlier. On physical examination of claimant's lower back, Dr. Ricca found mild tenderness of the paraspinal muscles.

5. Claimant testified that he had lower back pain before riding the bicycle, but that riding increased his pain. Claimant bought the recumbent bicycle because he thought riding it would improve his arthritis symptoms. Claimant says he only rode the bike for 5 to 10 minutes before learning it was not for him. Although at hearing claimant minimized the importance of this history to the development of his symptoms, he thought it significant enough to report to Dr. Ricca on September 29th. More importantly, Dr. Ricca deemed the bicycle riding incident medically significant to claimant's history of developing symptoms.

6. Dr. Ricca referred claimant for a magnetic resonance imaging (MRI) scan of his lumbar spine on October 4, 2008. Dr. Ricca discussed the MRI results with claimant on October 6, 2008. Dr. Ricca wrote:

> I strongly believe that this issue was caused by [claimant's] activity at his workplace. He was lifting heavy bags prior to the onset of his symptoms. I suspect his rheumatoid arthritis has exacerbated the symptoms.

Dr. Ricca's opinion here is equivocal: It is unclear what "issue" Dr. Ricca believes was caused by work activity and what role his rheumatoid arthritis plays in exacerbating his symptoms. Dr. Ricca recommended claimant follow up with workers' compensation.

7. On October 10, 2008, Dr. Ricca noted claimant's symptoms more involved radiculopathy in his lower extremities than lower back pain. Dr. Ricca referred claimant to Orthopedic Surgeon Gary Ghiselli, M.D., who evaluated him on October 14, 2008. Claimant reported to Dr. Ghiselli that his back symptoms worsened without any inciting incident or specific injury. Claimant noted to Dr. Ghiselli that he had been performing increased driving and lifting heavy bags while working for employer. Dr. Ghiselli observed claimant displaying significant pain behaviors, including riding in a wheelchair. Dr. Ghiselli read the MRI as showing a degenerative disease process in claimant's lumbar spine, including slight spondylolisthesis at the L4-5 level, mild disk degeneration at the L3-4 level, and moderate disk protrusion at the L5-S1 level, with posterior displacement of the left S1

nerve root. Dr. Ghiselli diagnosed multifactorial symptom complex with significant pain behaviors. Dr. Ghiselli recommended conservative management, including epidural steroid injection (ESI) therapy.

8. Dr. Ghiselli referred claimant to Ronald S. Hattin, M.D., who administered an ESI on October 16, 2008. Claimant reported the following history to Dr. Hattin: Claimant's symptoms initially began in his right-sided lower back some two months earlier while driving a bus for employer; over the following two weeks, he experienced increasing pain radiating into the right greater than left lower extremity; and, around the end of September, he violently sneezed, causing symptoms of acute, severe pain in both lower extremities. Claimant rated his pain at 8 on a scale of 0 to 10, worse with sitting than standing. Dr. Hattin noted that claimant's MRI scan strikingly showed severe bilateral foraminal stenosis at the L4-5 and L5-S1 levels due to a combination of disk bulging, posterior ligamentum flavum buckling, and facet joint arthropathy from his degenerative arthritic process. Dr. Hattin attributed claimant's symptoms to chronic degenerative changes at the L4-5 and L5-S1 levels.

9. Dr. Hattin administered a repeat ESI on November 4, 2008. Claimant reported to Dr. Hattin that the first ESI completely resolved his right leg pain. The second ESI reduced claimant's residual left leg pain.

10. At employer's request, Henry J. Roth, M.D., performed an independent medical evaluation of claimant and examined him on January 27, 2009. Dr. Roth testified as an expert in the area of Physical and Occupational Medicine. Dr. Roth has taught other physicians how to analyze medical causation and is an expert in the area of assessing medical causation.

11. On February 4, 2009, Dr. Ghiselli performed surgery upon claimant's lumbar spine: A decompression with microdiskectomy at the L4-5 and L5-S1 levels, and a left sided fusion of the L4-5 level, using bone graft material. Crediting his testimony, claimant's surgical result has been very successful in alleviating his symptoms.

12. Dr. Ghiselli testified as an expert in the area of Orthopedic Surgery. Dr. Ghiselli had not reviewed records of claimant's past medical treatment. The Judge credits Dr. Ghiselli's testimony in finding the surgery reasonable and necessary in light of claimant's presenting symptoms. Dr. Ghiselli's surgical exploration revealed no problem with claimant's bone density. Dr. Ghiselli however observed evidence of rheumatoid arthritis during surgery. Dr. Ghiselli testified that, by history, claimant was unable to tie his symptoms to any specific injury. According to Dr. Ghiselli, claimant's activity of lifting luggage at employer possibly could contribute to symptoms from disk protrusion; similarly, riding the bicycle or sneezing could aggravate his underlying arthritic process or could contribute to his symptoms. Crediting

Dr. Ghiselli's medical opinion, any one of these activities is a possible cause of exacerbating claimant's underlying arthritic process.

13. The Judge finds that Dr. Ghiselli's testimony falls short of providing a medically probable cause of claimant's symptoms that is exogenous to the underlying disease process itself. In this respect, Dr. Ghiselli's testimony is consistent with the testimony of Dr. Roth.

14. The Judge credits Dr. Roth's testimony in finding the following: There is no medical record history of claimant experiencing an onset of lower back symptoms in association with his work at employer. Claimant instead has an underlying degenerative disease process in his lumbar spine that he was genetically predisposed to develop and that is consistent with his age of 62 years. The underlying disease process is erosive to the ligaments and bony structures of claimant's lumbar spine. Claimant has a similar disease process in his cervical spine. Claimant's underlying disease process has been accelerated by his metabolic syndrome, including his diabetes, cholesterol, and hypertension, which disrupts blood supply and causes oxygen starvation to the structures of his lumbar spine. In addition, claimant's rheumatoid arthritis disease is an inflammatory condition, which contributes to the destructive and erosive degeneration of the structures of his lumbar spine. And claimant's habit of tobacco dependency has further accelerated the underlying disease process in his lumbar spine. Claimant's underlying spine disease has progressed to the stage where his symptoms are typical for the disease, spontaneous, and unrelated to any exogenous event. Because of the progression of his spine disease, claimant is intolerant of activity, such as, luggage handling. Claimant's underlying spine disease is the medical cause of his need for treatment. Because the MRI findings demonstrate the absence of any acute change to the anatomy of claimant's disks or osteoarthritis, it is medically improbable that claimant's work activity caused any change to the anatomy of his lumbar spine. Instead, the natural progression of claimant's underlying spine disease, and not his work activity at employer, likely caused his symptoms and presentation.

15. Claimant failed to show it more probably true than not that the hazards of his employment caused, intensified, or, to a reasonable degree, aggravated claimant's underlying spine disease. Although claimant associates the onset of his symptoms to handling luggage while driving the AB Route on 6 of his shifts in August and September of 2008, the Judge has credited the medical opinion of Dr. Roth in finding it more probably true that the natural progression of claimant's underlying spine disease, and not his work activity, proximately caused his need for medical treatment and his resulting disability.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues he has proven by a preponderance of the evidence that he sustained an occupational disease type injury arising out of the course and scope of his employment. The Judge disagrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), *supra*, as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, **and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.**

(Emphasis added).

This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

Here, the Judge found claimant failed to show it more probably true than not that the hazards of his employment caused, intensified, or, to a reasonable degree, aggravated claimant's underlying spine disease. Claimant thus failed to prove by a preponderance of the evidence that he sustained compensable occupational disease type injury.

As found, claimant associates the onset of his symptoms to handling luggage while driving the AB Route on 6 of his shifts while working for employer in August and September of 2008. The Judge however credited the medical opinion of Dr. Roth in finding it more probably true that the natural progression of claimant's underlying spine disease, and not his work activity at employer, proximately caused his need for medical treatment and his resulting disability.

The Judge concludes that claimant's claim for workers' compensation benefits under the Act should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's claim for workers' compensation benefits under the Act is denied and dismissed.

DATED: _July 2, 2009_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-662-964

CORRECTED FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

No further hearings have been held in the above-captioned matter. On June 24, 2009, the ALJ's Full Findings of Fact, Conclusions of Law and Order was sent to the parties. On July 2, 2009, Claimant filed a timely "Unopposed Motion for Amendment of Order," stating, *inter alia,* that the decision did not order Respondents to pay for Claimant's lidocaine prescription, although the ALJ determined that it was reasonably necessary. The motion is well taken and the decision below is amended accordingly.

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on March 16, 2009 and June 1, 2009, in Denver, Colorado. The hearing was digitally recorded (reference: 3/16/09, Courtroom 3, beginning at 8:34 AM, and ending at 5:00 PM; and, 6/1/09, Courtroom 1, beginning at 8:30 AM, and ending at 11:27 AM).

At the conclusion of the hearing, the ALJ established a briefing schedule (briefs to be filed electronically). Claimant's opening brief was filed on June 9, 2009. Respondents' answer brief was filed on June 15, 2009. On June 16, 2009, Claimant indicated that he would not be filing a reply brief. The matter was deemed submitted for decision on June 16, 2009.

ISSUES

The issues to be determined by this decision concern permanent total disability (PTD), reasonably necessary medical benefits, and bodily disfigurement. During the hearing, Respondents withdrew their affirmative issue of whether the Claimant was barred from PTD benefits on the ground that the Claimant rejected an offer of modified employment. Claimant has the burden of proof, by a preponderance of the evidence, on all issues remaining for determination.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. On September 9, 2005, the Claimant sustained an injury to his cervical spine while working for employer.

2. On October 21, 2005, Claimant underwent a cervical fusion by Robert T. Vraney, M.D. On October 13, 2006, Dr. Vraney noted the fusion to be solid. On April 27, 2007, B. Andrew Castro, M.D., reviewed claimant's MRI (magnetic resonance imaging) studies, noted the "solid fusion", and stated that he did not recommend any further surgical intervention.

3. Jeffrey A. Wunder, M.D., originally placed Claimant at maximum medical improvement (MMI) on September 21, 2006. Prior to doing so he ordered a Functional Capacity Evaluation (FCE) and that test was completed on September 19, 2006.

4. At Dr. Wunder's request, Claimant began treating with psychologist Peter J. Vicente, Ph.D., on April 25, 2006. After multiple psychological tests Dr. Vicente was of the opinion that "The patient is not focused on compensation or litigation gains, nor is malingering an issue." Dr. Vicente's report also states that "there is no indication of a strong addiction potential."

5. The FCE conducted on September 19, 2006 found that the Claimant could only lift 10 pounds on an occasional basis, had to take unscheduled breaks during testing, and fell in the "below competitive" range for many of the tests administered due to increased neck pain. The validity testing conducted during that FCE found that the Claimant gave a consistent effort. There were no findings of submaximal effort on that FCE's validity testing. Several of the tests were stopped due to concerns for the Claimant's safety. The ALJ finds that the restrictions imposed in the FCE were temporary, one and one-half years before the Claimant reached MMI, and were superseded by the permanent restrictions imposed by Claimant's authorized treating physicians (ATPs).

6. Ultimately, Dr. Wunder, who had been an ATP since March 2006, and the Claimant's current primary treating physician, placed the Claimant at MMI on April 28, 2008, and rated him with a 23% permanent impairment to his cervical spine (whole person). Dr. Wunder recommended one year of maintenance medications. He assigned permanent work restrictions of a maximum 20 pounds lift, pull, or carry, with occasional overhead work.

7. On August 7, 2008, the Claimant underwent a follow up Division Independent Medical Examination (DIME) with Kristin D. Mason, M.D., who agreed with Dr. Wunder's MMI date of April 21, 2008. Dr. Mason rated the Claimant with 26% impairment to his cervical spine and with 2% mental impairment. Dr. Mason declined to rate permanent impairment to Claimant's right lower extremity (RLE) or for swallowing issues.

8. Respondents filed a Final Admission of Liability (FAL), consistent with the opinions of Dr. Mason. Claimant initially challenged, but later withdrew his challenge to the opinions of the DIME.

9. Claimant does not have a high school diploma or GED. His work history is entirely in the restaurant industry. He was employed as an executive chef with Employer as of September 9, 2005, and prior to that had worked as an executive chef, line chef, sous chef, saucier, and owned his own restaurants.

10. Claimant's work as an executive chef with Employer required that he supervise the functions of the kitchen, including ordering food, receiving food, cooking food, working as a line cook, washing dishes, mopping floors, heavy cleaning, lifting, bending, and a lot of cooking. There were times when he was the only one present in the kitchen. Physical requirements of his work as an executive chef required being able to maneuver ninety (90) pound boxes of meat, and repetitive use of his upper extremities for cutting, chopping, lifting pans, making sauces, lifting racks of clean dishes, and mopping. Katie Montoya, Respondents' vocational expert, is of the opinion that Claimant can no longer perform his executive chef job.

11. Claimant has looked for work since he last worked, but he does not believe that he is physically able to perform any of the jobs he has applied for. Claimant has not been offered any jobs or interviews for jobs for which he has applied. He has applied for jobs posted on-line and jobs identified by Katie Montoya, Respondents' vocational expert, but he does not believe that he can physically perform any of those jobs due to his limitations, many of which are self imposed and not consistent with his ATPs' permanent medical restrictions. Claimant has also sought work through Workforce Colorado, but was referred to the Division of Vocational Rehabilitation. He has not been offered any vocational rehabilitation services through the Division of Vocational Rehabilitation (DVR). This fact is neutral because the ALJ can neither infer that Claimant did **not** meet the DVR's criteria nor that Claimant was **not** capable of being vocationally rehabilitated.

Medical Opinion

12. The restrictions of medical providers, including Dr. Wunder and Matthew Brodie, M.D., as well as the opinions of Dr. Mason and Tashoff Bernton, M.D., are more persuasive and credible than the limitations of Doris Shriver, Claimant's vocational expert. The ALJ finds that Shriver's restrictions are not supported by the weight of the medical evidence.

13. Dr. Wunder, an ATP, was of the opinion that the Claimant's only current objective findings are restricted cervical range of motion and some sensory deficits in the left C-6 distribution which have changed over time. On March 3, 2008, Claimant's electrodiagnostic studies that had been previously considered abnormal, were interpreted as normal.

14. Dr. Wunder referred the Claimant for a functional capacity evaluation (FCE). In the report of the FCE, the evaluator noted that "the findings from this evaluation be correlated with objective physical findings and is subject to further interpretation and determination of validity by the treating physician. Dr. Wunder stated that an FCE is like a diagnostic test, such as an MRI. It needs to be interpreted by a physician in light of

clinical information. The ALJ finds Dr. Wunder's opinion in this regard persuasive and credible.

15. Dr. Wunder assigned the Claimant permanent work restrictions of lifting, pushing, and pulling of up to 20 pounds on an occasional basis, and "that the claimant is also restricted to occasional work and occasional reaching overhead." Dr. Wunder based his restrictions on information that could be objectively verified, the history of surgery, the FCE, and his twenty three years of medical experience in dealing with patients with similar conditions.

16. Dr. Bernton agreed with the restrictions of Dr. Wunder, but stated that Claimant "is probably able to function at a greater level than this."

17. According to Dr. Wunder, it is not reasonable to rely on the Claimant's subjective report of symptoms in assigning work restrictions. Multiple other physicians, including Dr. Brodie, Dr. Mason, and Dr. Bernton have questioned the reliability of Claimant's subjective complaints.

18. Dr. Bernton noted in his April 3, 2007 report that the Claimant has "developed a large number of pain complaints which are either unexplained on an objective basis or disproportionate to those findings which are present." Dr. Bernton states that "conscious magnification of symptoms and misrepresentation of functional ability (e.g. malingering) is present in this case."

19. Dr. Mason commented in her DIME report that, at times "it appears he does somewhat distort his report and there have been some inconsistencies of his presentation." The ALJ finds that this independent opinion of a DIME corroborates Dr. Bernton's opinion concerning magnification of symptoms, thus, enhancing Dr. Bernton's credibility in this regard.

20. Dr. Brodie was of the opinion that "there are non-organic factors driving this case." According to Dr. Brodie, Claimant's diagnostic studies and "documented organic illness would not constitute the need for him to not be able to return to his gainful employment," and that his perceived disabilities are being primarily driven by subjective complaints of pain.

21. Dr. Wunder was of the opinion that the "patient's reported functional disability has been in excess of objective findings."

22. The ALJ finds that the permanent work restrictions assigned by Dr. Wunder take into account the Claimant's objective and subjective complaints and are reasonable.

23. Following his surgery, the Claimant was diagnosed with a deep venous thrombosis (DVT), for which he received medical treatment.

24. Claimant has complained of RLE pain and limitations that he attributes to the DVT. However, the medical evidence shows that the DVT healed and should not be causing functional limitations. In discussing the Claimant's right leg, Dr. Mason, the DIME, noted "the patient is, to some extent, exaggerating his complaints. I do not find anything objectively wrong with the leg. Multiple subsequent vascular studies have shown resolution of the blood clot and he has been viewed on at least some of the surveillance videotapes to present a different functional picture with respect to gait than he presents in the office." Dr. Mason stated there was no objective basis for assigning a permanent impairment. Claimant withdrew his challenge to the DIME and thus his challenge to this opinion.

25. Claimant testified that he is ambidextrous, but that he is basically right handed. Claimant has alleged difficulties with his right upper extremity (RUE) as a result of his injury. Diagnostic studies have been performed which have revealed no abnormalities in the RUE. Multiple physicians, including Dr. Wunder, Jeffrey Sabin, M.D., and Dr. Bernton, are of the opinion that Claimant's RUE complaints are not related to his work injury. Both Dr. Wunder and Dr. Bernton stated that Claimant has no limitation with respect to the use of his RUE. Claimant's complaints of symptoms in the RUE are not supported by objective medical evidence.

26. Dr. Mason's report noted that the mechanics of Claimant's swallowing was affected by his cervical fusion hardware, but she did not find that he had a rateable impairment for that condition. She did provide him with a two percent (2%) whole person rating for his psychological condition, which had stabilized with medication, and a 26% whole person impairment to his cervical spine, which included an impairment rating for sensory deficits in his left upper extremity. Claimant also testified regarding his swallowing difficulties. The DIME, however, specifically noted that there was no impairment for swallowing, nor has Claimant identified any credible work restrictions as a result of any swallowing issues.

27. Gary Gutterman, M.D., a psychiatrist and an ATP, is of the opinion that Claimant is "capable or returning to the workforce from a psychiatric and cognitive perspective."

28. Dr. Mason, the DIME, completed mental impairment worksheets, and rated Claimant with a 2% mental impairment due to his condition being stable on medication. Dr. Mason completed a Mental Impairment Worksheet and noted no impairment in activities of daily living, including travel, social functioning, thinking, concentration, judgment, or adaptation to stress. Claimant withdrew challenge to DIME.

29. Dr. Bernton was of the opinion that the Claimant is capable of working full time within the restrictions outlined by Dr. Wunder.

30. Dr. Wunder and Dr. Bernton were each of the opinion that there is no medical basis for the assignment of work restrictions on the Claimant's ability to sit,

stand, or walk. Dr. Bernton further was of the opinion that there is no medical basis for Claimant's allegation that he would need to take unscheduled breaks during a workday.

31. Christopher Ryan, M.D., who testified on behalf of the Claimant, last saw Claimant on January 16, 2009. Dr. Ryan was of the opinion that Claimant could lift 20 lbs. only occasionally and was restricted from lifting and carrying 10 lbs. frequently. Dr. Ryan also restricted neck movements and overhead activities. The ALJ finds that Dr. Ryan did **not** persuasively relate many of his restrictions to the Claimant's work-related injury of September 9, 2005. The ALJ resolves the conflict between the opinions of Dr. Ryan and the opinions of ATP Dr. Wunder and Respondents' IME doctors, Dr. Bernton and Dr. Brodie in favor of Drs. Wunder, Bernton and Brodie. Therefore, the ALJ finds that the three later physicians' opinions outweigh the opinion of Dr. Ryan.

Commutable Labor Market

32. There is a dispute concerning the Claimant's commutable labor market. Manning Pickett, M.D., and Christopher Ryan, M.D., both stated opinions that the Claimant is restricted from extended driving.

33. Dr. Wunder was of the opinion that it would be reasonable for the Claimant to take a short break of 5 to 10 minutes after driving 45 minutes to an hour before continuing to drive. Claimant's injuries do not otherwise limit his ability to drive. Claimant maintains a valid Colorado driver's license.

34. Neither Dr. Pickett nor Dr. Ryan provided a persuasive explanation concerning the medical basis of the Claimant's alleged inability to drive long distances within the restrictions outlined by Dr. Wunder. To the extent that their opinions are based on Claimant's report of RLE pain, as noted by the DIME, Dr. Mason, the DVT healed and there is nothing objectively wrong with his leg.

35. At the time of his injury, Claimant was living in Wheat Ridge. During this claim, he moved to Bailey, Colorado. Therefore, his commutable labor market extends to a 45-minute drive from Bailey. The ALJ takes administrative notice that this would include parts of the Metro Denver area.

36. Claimant testified that he has difficulty driving and when he drives, he stops to take breaks. Claimant's testimony that he is unable to drive for extended periods of time without multiple breaks is contradicted by the testimony of investigator Chris Selle who observed the Claimant driving his vehicle continuously for 60 minutes.

37. Public transportation is available from Pine Junction, which is 10 miles away from Claimant's home, to the Denver metro area. Dr. Wunder and Dr. Bernton each persuasively expressed opinions that the Claimant has no restrictions in his ability to use public transportation.

38. According to Katie Montoya, Respondents' vocational expert, and based on the opinions of Dr. Wunder and Bernton concerning the Claimant's ability to drive, plus the availability of public transportation to the Denver metro area from Bailey, the Claimant's commutable labor market includes the Denver metro area.

Vocational Experts

39. Katie Montoya, Respondents vocational expert, performed a vocational evaluation of Claimant that included a personal interview. Montoya performed a variety of computer analysis, a review of occupational job descriptions and the Dictionary of Occupational Titles (DOT), a review of job openings, and she contacted potential employers.

40. According to Montoya, the Claimant is not capable of returning to work as an Executive Chef, his pre-injury occupation.

41. According to Montoya, the Claimant "is a skilled individual" and has acquired various skills through his work history including restaurant ownership, restaurant management, supervising and evaluating staff, ordering food, inventory, customer service, putting together events, scheduling, interviewing, quality control, and making establishments profitable. Claimant's work history documenting these skills and his "extensive computer skills" is contained in his resume [admitted into evidence as Respondents' Exhibit A-1]

42. Claimant contends that his education level has precluded him from certain jobs. Claimant admitted, however, to telling medical providers that he had graduated from high school when he had not. Shriver agreed that the Claimant had significant skills in the food service industry that could substitute for education requirements. Claimant did not need a high school diploma to complete or perform work as reflected in his work history. During that work history, Claimant developed transferable skills for work he could perform within his current restrictions.

43. Montoya stated that, in evaluating vocational capabilities, it is more reasonable to rely on the opinions of treating physicians regarding a Claimant's work restrictions. In reaching her conclusion that Claimant is employable, Montoya relied on the restrictions of Dr. Wunder and Dr. Brodie, as well as the restrictions of the DIME, Dr. Mason, and Dr. Bernton. Montoya observed that the restrictions of these four physicians were consistent with one another, and the ALJ so finds. Montoya noted that these restrictions essentially allow for a sedentary to light work classification. The consistency of the restrictions among medical providers makes the restrictions highly persuasive and credible.

44. Montoya is of the opinion that Claimant is capable of performing jobs including customer service, cashier, food service supervisor, host, sandwich maker, order clerk. Montoya is further of the opinion that Claimant has the capacity to return to even higher level jobs by using previous contacts and knowledge of the food service industry.

According to Montoya, each of these jobs is within Claimant's vocational capabilities and within the restrictions of Dr. Wunder, Dr. Brodie, Dr. Bernton, and Dr. Mason. Montoya is of the opinion that these jobs are available within Claimant's commutable labor market.

45. Doris Shriver, Claimant's vocational expert, is of the opinion that Claimant is not capable or earning wages. Shriver and the Claimant stated that, before the day of the hearing, Shriver had never met Claimant. Shriver is of the opinion that "non exertional limitations", including the Claimant's inability to sit, stand, walk, and reach, resulted in a vocational profile which rendered the Claimant unemployable and that it was not even worth it for Claimant to apply for any jobs.

46. The reliance by Shriver on Claimant's "non-exertional" limitations in support of her opinions that Claimant is unemployable is not consistent with the medical evidence, including the testimony of Dr. Wunder and Dr. Bernton, and the reports of Dr. Brodie and DIME Dr. Mason. Shriver's opinions are based on Claimant's subjective report instead of the objective medical findings. The fact that the critical mass of Shriver's opinion that Claimant is unemployable is her heavy reliance on Claimant's subjective limitations and not on the medical restrictions of Claimant's primary ATP and the DIME physician substantially undercuts the persuasiveness of Shriver's ultimate opinion that Claimant is unemployable.

47. Montoya acknowledged that, if she only considered what Claimant reported about his physical capabilities, Claimant would not be able to work, but to do so would require her to disregard the medical evidence.

48. Montoya was of the opinion in her testimony and in her report that, after considering the objective information, Claimant's medical status, his entire vocational profile, Claimant maintains the capacity to return to work.

49. The opinions of Katie Montoya are more consistent with the medical evidence and are more credible and persuasive than the opinions of Doris Shriver. The ALJ finds that the Claimant is able to earn wages within his medical restrictions and his entire vocational profile.

50. Claimant's age, transferable skills, work restrictions, and ability to commute to the Denver labor market via public or private transportation demonstrates that he is capable of earning wages.

51. Claimant has failed to prove, by a preponderance of the evidence that he is incapable of earning wages in the competitive job market. Therefore, Claimant has failed tom prove that he is permanently and totally disabled. The Claimant reached MMI on April 28, 2008.

Continued Medical Treatment/Post-MMI Maintenance Treatment

52. According to the opinions of Dr. Wunder, the ATP, and Dr. Bernton, Claimant's request for treatment with narcotic medications is no longer reasonable and necessary.

53. A respectable minority, Dr. Ryan, agrees that Dr. Pickett's treatment, including the continued prescription of narcotics, is reasonably necessary. The ALJ resolves this conflict in favor of the opinions of Dr. Wunder and Dr. Bernton and against Dr. Ryan's opinion.

54. Dr. Wunder has provided extensive treatment and referrals to the Claimant including radiological studies, electrodiagnostic studies, specialist referrals, and other care. Dr. Ryan, called to testify by the Claimant, expressed the opinion that the care provided by Dr. Wunder has been appropriate, that Dr. Wunder has made necessary referrals, and "went the extra mile and then some" in his treatment of Claimant. Dr. Bernton was of the opinion that the care provided by Dr. Wunder to Claimant has been in compliance with the Division of Workers' Compensation Medical Treatment Guidelines.

55. When Dr. Wunder received an unexpected result of a random urine drug screen, which included the presence of marijuana and the absence of a prescribed medication, Dr. Wunder determined that it was no longer reasonable and necessary for the Claimant to be treated with narcotic medications. Other physicians, such as Dr. Brodie, an ATP, have raised questions about drug seeking behavior by Claimant.

56. Claimant has received medication from Dr. Pickett without the knowledge of Dr. Wunder. Dr. Ryan and Dr. Wunder each agreed that it is inappropriate for the Claimant to be receiving medications from multiple physicians.

57. When Dr. Wunder refused to prescribe further narcotic medications, Claimant obtained narcotic medications from Dr. Pickett. Dr. Bernton noted that "It is common in such situations with patients to seek another physician who may be willing to prescribe habituating medications; however, I believe this would be medically contraindicated."

58. Claimant desires to treat with Dr. Pickett because Dr. Pickett has been willing to provide narcotic medications and support Claimant's claims of disability where other physicians treating the Claimant for this claim have refused.

59. Dr. Bernton cautioned in his April 3, 2007 report that the failure of treating physicians to take into account the Claimant's misrepresentation of his symptoms would result in inappropriately prolonged medical care and inappropriately expanded disability. Dr. Wunder is aware of these issues in his treatment of Claimant. There is a question whether Dr. Pickett is considering these issues in his treatment of Claimant with narcotic medications that Dr. Wunder will not prescribe.

60. Dr. Bernton was of the opinion that there are non-narcotic treatments that would be reasonable to manage Claimant's pain complaints.

61. Dr. Wunder is still willing to continue to treat the Claimant for the effects of his work injury.

62. Claimant is seeking narcotic and other medication from Dr. Pickett. Claimant has demonstrated non-compliance with the narcotics contract with Dr. Wunder, obtaining medications and other substances on a surreptitious basis. The medical treatment that the Claimant is requesting from Dr. Pickett, principally continued narcotic prescriptions is not causally related to, or reasonably necessary to treat Claimant's admitted injury. Therefore, Claimant has failed to prove, by preponderant evidence that Dr. Pickett's narcotic prescriptions are causally related to, or reasonably necessary to treat the Claimant for the effects of his admitted injury. The lidocaine cream recommended by Dr. Pickett is reasonable and necessary treatment for the Claimant, and related to the injuries he sustained on September 9, 2005. Dr. Pickett recommended the lidocaine cream to provide pain relief that Claimant was not able to get from patches, because the hair on his body made it difficult for him to use adhesive patches, which he had tried previously.

63. Claimant was being prescribed Oxy IR, a narcotic medication, by ATP Dr. Wunder until Dr. Wunder obtained the results of a urine screen dated October 13, 2008. Dr. Wunder stopped Claimant's narcotic medication after that urine screen, and on December 15, 2008 stated that he no longer needed to see Claimant. Dr. Pickett has since prescribed OxyIR and a lidocaine cream for Claimant. The ALJ finds that the lidocaine is reasonably necessary to treat the Claimant's work-related condition. The Oxy-IR is **not** reasonably necessary.

Disfigurement

64. Claimant manifested a three-inch surgical scar on the front, right side of his neck, plainly visible to public view and causally related to his admitted injury.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions

(this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). As found, the ultimate opinion of Katie Montoya that Claimant is employable is based on more reliable study and underlying medical opinion than the opinion of Doris Shriver that Claimant is unemployable because Doris Shriver relied on Claimant's subjective (non-exertional) limitations and failed to appropriately take into account the permanent medical restrictions imposed by Claimant's ATPs and corroborated by independent medical examiners. Therefore, the ALJ resolves this conflict in the ultimate employability opinion in favor of Katie Montoya's opinion and against Doris Shriver's opinion. Also, as found, the opinions of the ATP, Dr. Wunder, and Dr. Brodie, and Dr. Bernton, concerning Claimant's permanent medical restrictions are persuasive, credible and only disputed by Dr. Ryan.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits, beyond those admitted by the Respondents. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001).
As found, the Claimant has failed to sustain his burden with respect to permanent total disability and the reasonable necessity of continued narcotic prescriptions by Dr. Pickett. Insofar as Respondents impliedly argued, in their answer brief, that Dr. Pickett should be de-authorized as a treating physician, Respondents failed to establish that de-authorization of Dr. Pickett is warranted. As found, a respectable minority, Dr. Ryan, agrees that Dr. Pickett's treatment is appropriate, but the ALJ found the majority opinion in this regard more persuasive and credible.

c. An employee is permanently and totally disabled if he is unable to earn any wages in the same or other employment. § 8-40-201(16.5)(a) C.R.S. (2008). In determining whether a claimant is permanently and totally disabled, an ALJ may consider the claimant's "human factors," including the claimant's age, work history, general physical condition, education, and prior training and experience. *Weld County School District RE-12 v. Bymer,* 955 P.2d 550 (Colo. 1998*); Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P.2d 701 (Colo. App. 1999); *Joslin's Dry Goods Co. v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001). The test for permanent total disability is whether employment exists that is reasonably available to the claimant

under her particular circumstances. *Id.* This means whether employment is available in the competitive job market, which a claimant can perform on a reasonably sustainable basis. It does **not** mean that an injured worker can actually find a job that he can perform within his medical restrictions. As found, Claimant has worked as an executive chef (a high-level job in the restaurant business) and owner of a restaurant. According to Katie Montoya, Claimant has significant transferable skills. As found, even Montoya conceded that if she accepted Claimant's self imposed restrictions, it would then be her opinion that the Claimant could not work. Montoya, however, accepted the permanent medical restrictions of the ATPs and, based on these restrictions, was of the opinion that Claimant is employable. As found, the ALJ determined that Claimant is employable and **not** permanently and totally disabled.

d. Respondents are liable only for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. § 8-42-101(1)(a), C.R.S. (2008); *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714 (Colo. 1994). It is a claimant's burden to prove that an industrial injury is the cause of a subsequent need for medical treatment, whether that treatment is in the form of maintenance medical care or care designed to cure or relieve the effects of the industrial injury. *City of Durango v. Dunagan*, 939 P.2d 496 (Colo. App. 1997). The Claimant bears the burden of proof to establish the right to specific medical benefits, by a preponderance of the relevant evidence. *See* *Valley Tree Service v. Jimenez*, 787 P.2d 658 (Colo. App. 1990). Claimant's request for treatment with narcotic medications is no longer reasonable and necessary, based on the persuasive and credible testimony of Dr. Wunder and Dr. Bernton, which, as found, resolves the medical issue against treatment with narcotic medications.

e. The Claimant has sustained a serious permanent disfigurement to areas of Claimant's body normally exposed to public view. *See* § 8-42-108 C.R.S.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Claimant's claim for permanent total disability benefits is hereby denied and dismissed. The Final Admission of Liability, dated September 5, 2008, is hereby affirmed, adopted, and incorporated by reference herein as if fully restated.

B. Claimant's request for continued treatment with narcotic medications by Manning Pickett, M.D., with the excep[tion of the lidocaine prescription, is hereby denied and dismissed as not reasonably necessary to treat the effects of the admitted injury. Respondents are liable for trhe costs of the lidocaine prescription. Respondents' implied request to de-authorize Dr. Pickett as an authorized treating physician is hereby denied and dismissed. Jeffrey A. Wunder, M.D., and Dr. Pickett, remain the Claimant's authorized treating physicians for the provision of treatment to maintain the Claimant at

maximum medical improvement and to prevent a deterioration of his work-related condition.

C. Claimant is awarded disfigurement benefits in the amount of $500.00 for the three-inch surgical scar on the front, right side of the his neck, as described in the above Findings.

D. Any and all issues not determined herein are reserved for future decision.

DATED this_____day of July 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-782-668

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that his claim is compensable under the Workers' Compensation Act of Colorado and thus the Respondent-Insurer is liable on the claim.
2. Whether Respondent-Insurer shall pay for all reasonable and necessary medical care to cure or relieve Claimant from the effects of this condition.
3. Whether Respondent-Insurer shall pay for Dr. Richman's evaluation of Claimant.
4. Whether Dr. Richman is Claimant's authorized treating physician.

FINDINGS OF FACT

1. Claimant drives a 15-passenger sized van, configured for carrying merchandise, for the Respondent-Employer.

2. Claimant has had a previous workers' compensation claim for his back with this same Respondent-Employer wherein he was given a 14% whole person rating in 1999.

3. By December 2008 Claimant had been experiencing increasingly severe pain in his back knees and shoulders. Claimant reported this to Respondent-Employer and he was only told to see a doctor. He was not referred to the Respondent-Employer's workers' compensation medical provider. Claimant then sought out Dr. Richman. Dr. Richman opines that Claimant has a work-related diffuse lumbar myofascial pain condition.

4. Respondent-Insurer sent Claimant to Dr. Beatty. Dr. Beatty opines that Claimant has a non-industrial degenerative back condition.

5. Based upon a totality of the evidence, the ALJ concludes that the more credible medical opinion under the circumstances is that of Dr. Richman. The ALJ finds the Claimant is credible.

6. Respondent-Insurer shall pay for all reasonable and necessary medical care to cure or relieve Claimant from the effects of this condition. Respondent-Insurer shall pay for Dr. Richman's evaluation of Claimant.

7. Dr. Richman is Claimant's authorized treating physician.

8. Respondent-Insurer shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

9. Any and all issues not determined herein are reserved for future decision.

CONCLUSIONS OF LAW

1. A worker's compensation claimant must prove by a preponderance of the evidence that he or she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301, C.R.S.*; Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo.App. 2000); *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett,* 33 P.2d 1230 (Colo.App. 2001). The facts in a worker's compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. Claimant bears the burden of proof by a preponderance of the evidence that his or her employment bears a direct causal relationship to the injury. *Finn v. Industrial Commission of Colorado,* 437 P.2d 542 (Colo. 1968), *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo.App. 1999); *Snyder v. Industrial Claim Appeals Office,* 942 P.2d 1337 (Colo.App. 1997). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979).

2. The existing disease of an employee does not disqualify a claim if the employment aggravates, accelerates, or combines with the disease or infirmity to produce the disability for which workers' compensation is sought. *H&H Warehouse v. Vicory,* 805 P.2d 1167 (Colo.App. 1990).

3. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. COLORADO JURY INSTRUCTIONS, CIVIL, 3:16.

4. As found, Claimant's testimony is persuasive, as is the testimony of Dr. Richman. Claimant has presented sufficient evidence to demonstrate that he sustained a compensable industrial injury to his right shoulder on September 1, 2005.

5. The ALJ concludes that Claimant's back condition arose out of and in the course of his work activity with the Respondent-Employer, and is compensable under the Workers' Compensation Act of Colorado.

6. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo.App. 1990).

7. The ALJ concludes that Claimant is entitled to all reasonable and necessary medical care to cure or relieve him from the effects of the industrial injury, including care received thus far by Dr. Richman.

8. Once the right of selection passes to Claimant, it cannot be recaptured by the Respondent. *See Rogers v. Industrial Claim Appeals Office*, 746 P.2d 565 (Colo.App. 1987); *In re Davis*, W.C. No. 4-291-678 (ICAO, 05/17/99).

9. The ALJ concludes that the right of selection has passed to the Claimant and that Claimant's authorized treating physician is Dr. Richman.

ORDER

It is therefore ordered that:

1. The claim is compensable under the Workers' Compensation Act of Colorado and the Respondent-Insurer is liable on the claim.
2. Respondent-Insurer shall pay for all reasonable and necessary medical care to cure or relieve Claimant from the effects of this condition.
3. Respondent-Insurer shall pay for Dr. Richman's evaluation of Claimant.
4. Dr. Richman is Claimant's authorized treating physician.
5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
6. All matters not determined herein are reserved for future determination.

DATE: July 8, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-379

ISSUES

- Whether Respondents have overcome the Division Independent Medical Examination (DIME) physician's opinion regarding maximum medical improvement (MMI) and impairment rating including causation and apportionment; and

- Whether Claimant is entitled to additional medical benefits if she is not at MMI.

- The parties stipulated that Claimant's average weekly wage (AWW) entitles her to the maximum temporary total disability rate of $719.74. The Judge approved and accepted the AWW stipulation on April 17, 2009.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge makes the following Findings of Fact:

1. Claimant works as a dance professor for the Employer. Her job duties include teaching dance which involves demonstrating dance moves, dance steps, jumps and related maneuvers. Approximately 50 percent of her time working involves physical demonstration of dance moves. Her teaching schedule varies, but usually includes

seven courses per semester. During the semester she is in class more than 20 hours per week but less than 40.

2. In January 2006 Claimant had onset of right hip and groin pain while performing her job duties as a dance professor for Employer. Claimant reported the injury to the Employer and began treating with Dr. Cathy Smith in February 2006.

3. On February 6, 2006, Dr. Smith noted that Claimant had degenerative joint disease in the bilateral hips and no evidence of acute trauma. Dr. Smith's impression was "work-related incident resulting in right hip and groin strain." Dr. Smith prescribed physical therapy and medications. Dr. Smith also imposed work restrictions of no squatting or climbing, or forced external rotation or flexion of the hip.

4. Claimant first reported low back pain on July 10, 2006, although Dr. Smith added that Claimant presented for follow up evaluation of her right groin and sacroiliac (SI) joint strain in her report dated May 15, 2006.

5. On July 10, 2006, Claimant reported SI joint pain after having gone golfing, riding in her car and walking. Claimant told Dr. Smith that she had previously had "low back problems in the same place." Dr. Smith's impression was an exacerbation of the work-related right groin strain.

6. Dr. Smith treated Claimant's SI joint pain, which included physical therapy referrals, and added no bending and twisting to Claimant's work restrictions. By September 2006 Claimant reported resolution of the SI joint pain.

7. On December 4, 2006, Dr. Smith released Claimant from treatment without restrictions and found that Claimant had no permanent impairment. Claimant returned to work at full duty.

8. On May 24, 2007 Claimant returned for treatment through the workers' compensation system with Dr. Michelle Paczosa who diagnosed her with right hip pain and SI joint dysfunction. Dr. Paczosa referred Claimant for an MRI of the low back and right hip.

9. Dr. Paczosa also prescribed physical therapy for Claimant's SI joint and continued to treat Claimant's SI joint complaints until she placed Claimant at MMI. During most of the course of Claimant's treatment, Dr. Paczosa indicated the work related diagnoses included: "Back/Hip/SI joint strain". Dr. Paczosa changed her diagnosis to back strain and right hip avascular necrosis on July 10, 2007, but changed it back to "Back/Hip, SI joint strain" on September 12, 2007. Around this time, Dr. Paczosa referred Claimant to a podiatrist to address a leg length discrepancy discovered during physical therapy.

10. The leg length discrepancy was eventually treated by insertion of an orthotic in Claimant's shoe, which relieved some of Claimant's pain complaints.

11. Claimant saw Dr. Watkins on May 31, 2007 upon referral by Dr. Paczosa for an orthopedic consultation for the right hip pain. Claimant reportedly was unaware of a specific injury, but just noticed that after class she had a significant amount of pain and tightness in the groin and medial aspect of the thigh. Dr. Watkins evaluated the x-rays as showing minimal degenerative changes in the right hip. The MRI of the pelvis showed some focal areas of signal abnormality consistent with either early arthritis or focal osteonecrosis with degenerative signal in the superior labrum, right more extensive than left. The lumbar spine showed broad based disc bulging L4-L5 and L5-S1 with a little bit of foraminal stenosis, right more than left, mainly at L4-L5 level. Dr. Watkins assessed Claimant with degenerative disc disease of the lumbar spine with foraminal stenosis and suspected early arthritis with labral tear of the right hip.

12. On June 21, 2007, Claimant reported to Dr. Paczosa that her back popped out four months earlier at work with twisting while dancing. By that time, the Claimant had undergone an injection in the right hip which improved the pain levels.

13. Dr. Paczosa continued treating Claimant's low back and right hip until she documented in her May 1, 2008, treatment note that the Insurer had disallowed further physical therapy so she referred Claimant for a functional capacity evaluation. On May 19, 2008, Dr. Paczosa placed Claimant at MMI and specifically noted, "No further therapy was approved per the insurance company, and therefore the patient is here for a Level II impairment rating." The Judge infers that Dr. Paczosa would have continued Claimant's physical therapy had the Insurer authorized it. The Judge also infers that Dr. Paczosa felt that Claimant's back pain and SI joint dysfunction are related to or caused by Claimant's work based on the documented diagnoses and ongoing treatment.

14. The physical therapy recommended by Dr. Paczosa relieved Claimant's right hip and low back pain symptoms which have worsened since discontinuing physical therapy in May 2008.

15. Claimant previously reported to Dr. Coester on March 9, 2001, that: "1) pain is sometimes on the right side-other times, on the left side-& sometimes both sides 2) the pain varies from the hip, derriere, hamstring, outside of calf, to foot on both sides-sometimes both sides 3) pain in lower back 4) I feel my vertebra in low back shift back & forth often this increases…" Claimant reported that on April 4, 2000, she dragged a heavy trash can and 10 hours later she felt her back shift and could hardly walk or stand.

16. Dr. Coester reported on March 12, 2001, that claimant had reported to him that she had a history of back pain and intermittent bilateral leg pain since April 4, 2000. She also reported that she occasionally had severe pain that radiated into her hip.

He reported that the MRI showed a large central disc herniation at L4-5 with minimal impingement upon the nerve roots bilaterally.

17. On August 15, 2001, Dr. Coester discharged Claimant from care and opined that surgical intervention was ill-advised and premature at that time. He further noted that he advised Claimant to return if she had persistent difficulties. There are no medical records that reflect Claimant returned to Dr. Coester for persistent back pain.

18. In September 2005, Claimant sought treatment with Dr. Kindsfater for left hip pain. The medical records associated with this treatment do not mention complaints of low back pain or right hip pain.

19. On October 23, 2008, Claimant underwent a DIME with Dr. Brian Shea. Dr. Shea found that Claimant was not at MMI, and that her low back issues and SI joint complaints are related to her job as a dance professor. Dr. Shea specifically noted that the injury to Claimant's right hip caused structural decompensations which caused pain and impairment. He further noted that Claimant continued to have pain and limitation in her right hip, right SI joint and low back. Dr. Shea opined that Claimant needs additional treatment for sacral instability, which includes orthopedic treatment and physical therapy as well as Prolotherapy and medications. Dr. Shea opined that such treatment would stabilize her condition with a high probability of decreasing the hip joint, SI joint and lumbar problems.

20. Dr. Douglas Hemler performed an independent medical examination for Respondents on December 19, 2008 and issued a report. He also reviewed additional records that were obtained by Respondents and issued a supplemental report dated March 19, 2009.

21. Dr. Hemler opined that Claimant was clearly at MMI for the occupational condition on May 19, 2008. Dr. Hemler opined that Claimant sustained a strain syndrome of the right hip which was treated and that the lumbar spine and SI were not injured or clearly aggravated by the right hip strain. Dr. Hemler felt that Claimant's pain complaints were a result of her underlying degenerative osteoarthritis which did not appear to be aggravated by the right hip strain. Dr. Hemler felt that Dr. Shea inappropriately directed treatment to the SI region and inappropriately rated the lumbar spine because neither structure was injured.

22. In his March 19, 2009 report Dr. Hemler opined "It is highly unlikely that the dance activities themselves have resulted in premature ageing of the hip on the right or the left. A more likely circumstance is that she has progressive degenerative osteoarthritis of the right and left hip that would become symptomatic with a number of activities related to daily life and activities of daily living."

23. No clear and convincing demonstrates that Dr. Shea's opinions are incorrect. While it is true that Claimant experienced low back pain the past, the record reflects that her past symptoms had resolved. Claimant had not sought treatment for low back complaints since August 2001. Moreover, Dr. Paczosa felt that Claimant's back

symptoms were related to her right hip and groin injury, which is supported by her referrals for physical therapy and other treatment of the back complaints in conjunction with the right hip complaints. Furthermore, Dr. Hemler's opinion that Claimant has underlying degenerative osteoarthritis consistent with age and that performing her work duties as a dance professor did not aggravate or exacerbate the condition is unpersuasive given the opinions of Drs. Paczosa and Shea. Dr. Hemler merely disagrees with Dr. Shea's opinions regarding relatedness of the SI joint and low back complaints; however, it is not highly probable that Dr. Shea's opinions are incorrect. In addition, at the time Dr. Pacsoza placed the Claimant at MMI, her groin and hip pain had not resolved, which Dr. Shea confirmed in his report. Accordingly, Respondents have not overcome the opinions of Dr. Shea regarding MMI and relatedness of Claimant's low back and SI joint complaints.

24. Claimant has established that she is entitled to the medical treatment recommended by Dr. Shea. Dr. Shea's opinion that Claimant needs additional treatment for sacral instability, which includes orthopedic treatment and physical therapy as well as Prolotherapy and medications is persuasive. Dr. Shea opined that such treatment would stabilize her condition with a high probability of decreasing the hip joint, SI joint and lumbar problems. No persuasive medical opinions were offered to dispute Dr. Shea's recommendations. Moreover, Claimant credibly testified that the physical therapy prescribed by Dr. Paczosa was relieving her symptoms and without it, her symptoms have worsened.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Judge enters the following Conclusions of Law:

1. The ALJ's factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

Overcoming the DIME opinion

3. Sections 8-42-107(8)(b)(III) and (c), C.R.S., provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

4. The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. *Qual-Med v. Industrial Claim Appeals Office*, *supra.*

5. As found, Respondents have failed to overcome Dr. Shea's opinion that Claimant is not at MMI. No clear and convincing evidence demonstrates that the determination by Dr. Shea is incorrect. While it is true that Claimant experienced low back pain the past, the record reflects that her past symptoms had resolved. Claimant had not sought treatment for low back complaints since August 2001. Moreover, Dr. Paczosa felt that Claimant's back symptoms were related to her right

hip and groin injury, which is supported by her referrals for physical therapy and other treatment of the back complaints in conjunction with the right hip complaints. Furthermore, Dr. Hemler's opinion that Claimant has underlying degenerative osteoarthritis consistent with age and that performing her work duties as a dance professor did not aggravate or exacerbate the condition is unpersuasive given the opinions of Drs. Paczosa and Shea. Dr. Hemler merely disagrees with Dr. Shea's opinions regarding relatedness of the SI joint and low back complaints; however, it is not highly probable that Dr. Shea's opinions are incorrect. In addition, at the time Dr. Pacsoza placed the Claimant at MMI, her groin and hip pain had not resolved, which Dr. Shea confirmed in his report. Accordingly, Respondents have not overcome the opinions of Dr. Shea that Claimant is not at MMI nor have they overcome the opinion that Claimant's low back and SI joint symptoms are related to the original work injury to Claimant's right hip.

Medical Benefits

6. Section 8-42-101(1)(a), C.R.S., provides:

> Every employer … shall furnish … such medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury … and thereafter during the disability to cure and relieve the employee from the effects of the injury.

Respondents thus are liable for authorized medical treatment reasonably necessary to cure and relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990).

7. Claimant has established that she is entitled to the medical treatment recommended by Dr. Shea. Such treatment includes orthopedic treatment and physical therapy as well as Prolotherapy and medications. While it is true that The Lower Extremity Injury Medical Treatment Guidelines do not recommend Prolotherapy for lower extremity injuries, Dr. Shea recommended the treatment to cure and relieve her SI joint pain, lumbar spine pain which would then decrease the hip joint pain. No persuasive medical opinions were offered to dispute Dr. Shea's treatment recommendations. Moreover, Claimant credibly testified that the physical therapy prescribed by Dr. Paczosa was relieving her symptoms and without it, her symptoms have worsened. As such, Claimant is entitled to the treatment recommended by Dr. Shea in order to cure and relieve the effects of her work injury.

ORDER

It is therefore ordered that:

1. Claimant is not at MMI consistent with the opinions of Dr. Shea.

2. Respondents shall provide the Claimant with additional medical treatment consistent with the recommendations of Dr. Shea.

3. Because the ALJ has determined that Claimant is not at MMI based on the opinions of DIME physician, Dr. Shea, a determination on whether Respondents overcame Dr. Shea's opinions regarding permanent impairment and apportionment is unnecessary.

4. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

DATED: July 10, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-601-476 & WC 4-724-582

ISSUES

- Did the claimant prove by clear and convincing evidence that the DIME physician in W.C. No. 4-724-582 erred by apportioning the impairment rating for the April 2007 injury based on a determination that the claimant had pre-existing impairment caused by his 2004 industrial injury?

- If the claimant overcame the DIME physician's apportioned impairment rating, what is the claimant's correct impairment rating for the injury that he sustained in April 2007?

- Did the claimant prove by a preponderance of the evidence that the claim for the 2004 injury (W.C. No. 4-601-476) should be reopened on grounds of change of condition, error or mistake?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

These two claims were consolidated for purposes of conducting a hearing on related factual and legal issues. W.C. No. 4-601-476 concerns a low back injury the claimant sustained on January 8, 2004 (the 2004 injury), while employed by MI. W.C. No. 4-724-582 concerns a low back injury the claimant sustained on April 29, 2007 (the 2007 injury), while employed by HO.

In 2004 MI employed the claimant as a truck driver and delivery person. This was a relatively physical job that, in addition to driving the truck, required the claimant to lift weights in excess of 50 pounds. On January 8, 2004, the claimant sustained the sudden onset of low back pain while pulling a cart off of an elevator. The MI respondents admitted liability for this injury.

Dr. Donna Brogmus, M.D., was the authorized treating physician for the 2004 injury. Dr. Brogmus saw the claimant on January 9, 2004, and diagnosed acute lumbar strain. She removed the claimant from work and prescribed medications and physical therapy. The claimant returned to see Dr. Brogmus on January 13, 2004, and reported a 60 percent improvement in his condition and rated his pain at 3 on a scale of 0-10. Dr. Brogmus noted no "radicular symptoms." On January 20, 2007, Dr. Brogmus diagnosed a lumbar sprain/strain and released the claimant to full duty.

After the release to regular employment the claimant experienced some increased low back pain and stiffness. On February 17, 2004, Dr. Brogmus referred the claimant for an MRI to rule out a disc herniation. The claimant was also continued on medication and permitted to use a TENS unit that he previously acquired.

A lumbar MRI was performed on March 4, 2004. The MRI was reported by the reader as demonstrating a broad-based disc protrusion at the L3-4 level causing "relative stenosis," a central disc protrusion at L4-5 with annular tearing, and a central disc protrusion at L5-S1. Facet arthropathy was noted distal to the L2 level.

Dr. Brogmus examined the claimant on March 15, 2004. At that time Dr. Brogmus noted the MRI study revealed, "disc herniation, most significant at L3-4 by MRI." Dr. Brogmus reported that the claimant had pain of "0 to 1" and seemed to "be doing well." Dr. Brogmus noted that she discussed the case with a neurosurgeon who stated that he would not recommend surgery for a patient that is doing well. Dr. Brogmus recommended purchase of the TENS unit that the claimant used two to three times per week.

Dr. Brogmus again examined the claimant again on March 30, 2004. Dr. Brogmus noted the claimant had "steadily improved," had decreased his use of the TENS unit to one time per week, and "was doing everything at work." Dr. Brogmus reported that on examination the claimant did not have any significant tenderness to palpation of the low back, he could forward flex and touch his toes, he had normal toe walking, and exhibited normal tandem gait. Dr. Brogmus noted the claimant's affect was pleasant and appropriate and

he did not appear to be in any acute distress. Dr. Brogmus placed the claimant at maximum medical improvement (MMI) without permanent impairment, and released him to return to work at full duty. Dr. Brogmus recommended maintenance care of 3 months' medication, and one follow-up visit within 3 months if needed.

On April 5, 2004, the MI respondents filed a Final Admission of Liability (FAL) admitting that the claimant reached MMI on March 30, 2004 without permanent impairment. This FAL was based on Dr. Brogmus's report of March 30, 2004. The claimant did not challenge the FAL by seeking a hearing or requesting a Division-sponsored independent medical examination (DIME).

The claimant testified that his symptoms steadily improved after the 2004 injury. The claimant further stated he felt "fully recovered" when the MI respondents filed the FAL for the 2004 injury; therefore he did not object to the FAL. The claimant stated that he did not return to Dr. Brogmus after the FAL was filed because he did not believe he needed further treatment for the 2004 injury. The claimant stated he felt able to return to work at full duty.

The claimant testified that after he was placed at MMI he occasionally used the TENS unit for "flare-ups" of his back condition. The claimant recalled that the flare-ups occurred approximately every three months and caused more "stiffness" than pain. The claimant stated that he felt like he was experiencing a "muscle strain" and said that he tended to use the TENS unit after a "heavy day" at work. The claimant stated that by the next morning he was able to return to work. The claimant described these incidents of stiffness and pain as similar to episodes that he experienced before the 2004 injury.

The claimant left his employment as a delivery truck driver for MI in March 2006 when the company was sold. In May 2006 the claimant got a new job driving a fuel delivery truck for HO. The claimant described the jobs as similar in terms of the physical requirements. In addition to driving substantial distances the HO job required the claimant to lift caps off of fuel tanks located at or below ground level and to pull large hoses.

On May 29, 2009, Dr. Lee Whittemore, D.C., issued a report concerning chiropractic treatments that he provided to the claimant. Dr. Whittemore had treated the claimant for various problems since 1988. Dr. Whittemore stated that for the period of time between September 2004 and February 2007 he saw the claimant 17 times. The vast majority of these visits involved complaints of neck and upper back pain. The claimant complained of lower back problems on only one occasion in September 2006. At that visit the claimant advised Dr. Whittemore that he felt his lower back was "out of alignment."

The claimant testified that on April 29, 2007, he was delivering fuel. He was bent over securing a fuel cap when he suddenly experienced severe stabbing pain in his back. The claimant recalled that this pain caused him to drop to his knees and lay down for approximately 5 minutes. The claimant had not experienced similar pain before. The claimant notified his supervisor that he needed to be off for a few shifts but expected to be able to return to work.

On May 2, 2007, the claimant reported to Dr. William Basow, M.D., at Poudre Valley Health System. The claimant was seeking new leads for his TENS unit and had been told that the unit was out of date. Dr. Basow recorded that since the claimant was placed at MMI for the 2004 injury he had experienced a "chronic level of low back pain" and had been taking over the counter pain relievers. The claimant also gave a history that he experienced acute flare-ups of pain approximately every three months and used the TENS unit three to four times per day during the flare-ups. The claimant also stated that he had not had further treatment for his back since being placed at MMI by Dr. Brogmus, having experienced "only occasional minor back pains which did not require medical attention." The claimant denied radicular symptoms. The claimant also advised Dr. Basow that he was now driving a fuel delivery truck, and that this was much lighter work than he performed at the time of the 2004 injury. The claimant denied suffering any "reinjury" while performing the new employment. Dr. Basow referred the claimant for a new TENS unit, prescribed medication including Vicodin, and instructed the claimant to return in two weeks.

On or about May 12, 2007, the claimant experienced a sudden and severe increase in low back pain while he was at home watching television. On May 13, 2007, the claimant was taken to McKee Medical Center where he was admitted and underwent a lumbar MRI. On May 14, 2007, Dr. Robert J. Benz, M.D., examined the claimant in consultation. The claimant told Dr. Benz that he was experiencing a flare-up over the last two weeks. Dr. Benz recommended an epidural steroid injection (ESI). The claimant underwent the ESI and it provided some relief.

Dr. Benz again examined the claimant on May 21, 2007. Dr. Benz noted the claimant sustained the injury in 2004, and that the 2004 MRI showed no signs of any definite disc herniation at L3-4. Dr. Benz stated that after the 2004 injury the claimant was able to return to work full time. The claimant had changed jobs approximately one year prior to the May 2007 examination and began delivering gas products. Dr. Benz recorded the claimant was "doing well" until April 2007 when "he bent over to lift a cap off a ground tank when he had the onset of back pain and also then gradually developed some left leg symptoms." Dr. Benz reviewed the May 2007 MRI films from McKee Medical Center. Dr. Benz opined the MRI showed disc dessication and a left sided disc extrusion at L3-4 causing significant displacement of the thecal sac in comparison to the L4 nerve root. At L4-5 and L5-S1 there were signs of disc desiccation and mild bulging. Dr. Benz opined the claimant had sustained a new disc herniation on the left side, and that he had "recovered from his previous work comp injury." Dr. Benz further opined the "new injury" was related to lifting the cap off of the ground tank. Dr. Benz noted the claimant had been unable to return to work and recommended the claimant undergo an L3-4 discectomy to treat the herniation.

On May 24, 2007, the claimant returned to Dr. Basow. On this visit the claimant gave a different history than he gave to Dr. Basow on May 2, 2007. The claimant advised Dr. Basow that the most recent flare-up of back pain began in February 2007 when he slipped on some ice and fell at work. The claimant further stated that he suffered a sudden aggravation of the back pain in April 2007 when he bent over to take a gas cap off of a ground level opening. Dr. Basow inquired why the claimant had given a different

history on his initial visit. According to Dr. Basow, the claimant "convincingly" replied "that his initial visit was primarily just to get a new TENS unit; and he anticipated that his flare-up from these two injuries would resolve as had his previous flare-ups."

At the hearing, the claimant testified that he gave a false history to Dr. Basow on May 2, 2007, when he told Dr. Basow that he did not suffer any new back injury while working at HO. The claimant explained that he initially saw Dr. Basow because the doctor was located at the same clinic as Dr. Brogmus and he desired to obtain new leads for the TENS unit. The claimant further explained that he did not want to file a workers' compensation claim against HO because he was afraid of losing his job. The claimant admitted telling Dr. Basow that he suffered flare-ups of back pain every three months for which he used the TENS unit and over the counter medications, but did not recall giving a history of "chronic low back pain."

On June 26, 2007, the HO respondents filed a General Admission of Liability (GAL) admitting that the claimant sustained a compensable injury on April 29, 2007. The HO respondents admitted liability for medical benefits and temporary total disability benefits.

The HO respondents also designated Dr. Brian Thompson, M.D., as the authorized treating physician for the 2007 injury. Dr. Thompson first examined the claimant on June 14, 2007, and restricted the claimant from all work. On June 28, 2007, Dr. Thompson noted the claimant had a "three year history of low back problems," but "had a new injury which occurred on 4/29/07, bending over and reaching into fuel cap, pushing down valve cap, immediate worsening of pain in low back."

On July 3, 2007, Dr. Benz performed an L3-4 left-sided hemilaminontomy and discectomy to repair the herniated disc at L3-4.

Dr. Thompson placed the claimant at MMI on July 15, 2008. Dr. Thompson noted the claimant had improved but was still experiencing low back pain with occasional left leg radiation. Dr. Thompson diagnosed "L3/4 HNP" post-surgery related to the injury of April 29, 2007. Dr. Thompson assigned a 29 percent whole person impairment rating. This rating includes 10 percent for a specific disorder of the lumbar spine under Table 53 IIE of the AMA Guides (surgically treated disc lesion with residual medically documented pain and rigidity). Dr. Thompson also assigned 12 percent whole person impairment for reduced range of motion in the lumbar spine. Dr. Thompson wrote "none" with respect to apportionment. Dr. Thompson also assigned two percent impairment for the claimant's psychological condition.

Dr. Caroline Gellrick, M.D., performed a Division-sponsored independent medical examination (DIME) on November 18, 2008. Dr. Gellrick reviewed the claimant's medical records as they then existed and performed a physical examination. Dr. Gellrick opined the 2004 injury resulted in a "significant history" prior to the April 2007 injury. Specifically, Dr. Gellrick described the 2004 worker's compensation injury and the conservative treatment provided by Dr. Brogmus in 2004. Dr. Gellrick noted the 2004 MRI showed an L3-4 level broad-based disc protrusion causing stenosis, an L4-5 central disc protrusion with annular tearing, and an L5-SI disc protrusion. Dr. Gellrick noted that facet

arthropathy distal to L2 was present in 2004. Dr. Gellrick agreed with the date of MMI assigned by Dr. Thompson.

Concerning the degree of permanent impairment caused by the 2007 injury, Dr. Gellrick stated that she "differed slightly" from Dr. Thompson because "apportionment is considered." Dr. Gellrick stated the claimant "has a clear, pre-existing pathology present documented on MRI" as mentioned by several physicians soon after the 2007 injury. Dr. Gellrick specifically noted that the claimant "admitted with Dr. Basow to recurrent problems with the back for which he was using his TENS unit and initially presented to that office looking for replacement parts for his TENS unit." Dr. Gellrick stated that this history "indicates a chronic back condition; therefore, impairment with apportionment needs to be considered."

Dr. Gellrick opined that on the date of the DIME examination the claimant's overall impairment rating for the lumbar spine was 20 percent based on 10 percent impairment under Table 53 II(E) (surgically treated disc), 2 percent for additional levels of the spine under Table 53 II(F), and 9 percent for range of motion impairment. However, Dr. Gellrick determined that apportionment of the specific disorder impairment based on the 2004 injury is appropriate. Dr. Gellrick stated that "if one were to consider impairment rating with the [claimant] very functional and returning to full duty" after the 2004 injury he would be assigned 5 percent impairment under Table 53 II(B) (unoperated disc or soft-issue lesion with medically documented injury and a minimum of six months of medically documented pain and rigidity with or without muscle spasm associated with none to minimal degenerative changes on structural tests), and 2 percent impairment for multiple levels under Table 53 II(F). Thus, Dr. Gellrick apportioned 7 percent of the claimant's specific disorder impairment to the 2004 injury, leaving 5 percent whole person impairment related to the April 2007 injury. Dr. Gellrick declined to apportion any of the range of motion impairment to the 2004 injury because the claimant returned to full duty work for several years after the 2004 injury.

Dr. Gellrick's unapportioned rating for the 2007 injury was 29 percent whole person (including 1 percent for psychological impairment). Dr. Gellrick's apportioned impairment rating for the 2007 injury is 24 percent whole person based on the apportioned lumbar spine rating (14 percent) combined with other impairment attributable to the 2007 injury. The 24 percent whole person impairment rating includes 1 percent for psychological impairment.

On March 25, 2009, Dr. Christopher Ryan, M.D., performed an independent medical examination (IME) at the claimant's request. Dr. Ryan is board certified in Physical Medicine and Rehabilitation and is Level II accredited by the Division of Workers' Compensation. In his report Dr. Ryan undertook an extensive review of the claimant's medical records, as well as the DIME report issued by Dr. Gellrick. Dr. Ryan stated that he agreed with Dr. Gellrick's approach to rating the claimant's impairment, but he disagreed with her decision to apportion the rating. Dr. Ryan opined, contrary to Dr. Gellrick's report, that the claimant did not demonstrate any medical impairment prior to the occurrence of the 2007 injury. In support of this opinion Dr. Ryan stated that after the 2004 injury the claimant was able to return to work at a "heavy job," had only intermittent

back pain, and was for the most part asymptomatic. Dr. Ryan also opined that after the 2004 injury there was not medically documented pain and rigidity lasting 6 months so as to support an impairment rating under Table 53 II(B). Dr. Ryan also noted that the 2007 MRI revealed a disc extrusion that represented a "substantial" anatomic change when compared to the findings on the 2004 MRI.

Dr. Ryan also testified at hearing. Dr. Ryan reviewed the treatment records of Dr. Brogmus following the claimant's 2004 injury and agreed with her initial diagnosis of a lumbar sprain/strain. Dr. Ryan testified that he agreed with this diagnosis because the claimant's symptoms rapidly diminished and largely disappeared by the time he was placed at MMI for the 2004 injury. Dr. Ryan also noted the claimant's clinical course documented by Dr. Brogmus was not consistent with injury to the discs or the facet joints because the claimant's symptoms resolved rapidly and there was no report of radicular symptoms. Dr. Ryan also opined that the 2004 MRI findings of disc protrusions and facet arthropathy were "red herrings," meaning that the findings represented chronic degenerative changes unrelated to the 2004 injury. Dr. Ryan explained that it is common for asymptomatic people to exhibit positive MRI findings, including disc herniations. Consequently, there is no necessary relationship between a person's symptoms and findings on an MRI.

Dr. Ryan also reiterated his opinion that the medical records do not document 6 months of pain and rigidity as required by Table 53 II(B). With respect to rigidity, Dr. Ryan stated that rigidity is evidenced by "hardness" in the muscles, and that such hardness prevents flexibility. Dr. Ryan stated that the MMI report of Dr. Brogmus indicates that the claimant's range of motion measurements were mostly normal. Further, the claimant could touch his toes and bend backwards approximately 20 degrees. Dr. Ryan opined that it is unlikely the claimant was exhibiting any rigidity if he was able to perform these activities. Dr. Ryan also noted that the MMI report of Dr. Brogmus did not document 6 months of pain since the report was issued less than 6 months after the injury and the claimant's pain was resolved.

Dr. Ryan testified, based on his experience, that it is not unusual for truck drivers to experience intermittent muscle and joint pain of the back. This is true because drivers sit for prolonged periods and often use their backs to load and unload trucks. He also stated that a TENS unit would serve to treat this type of pain because it is a "pain signal blocker" that interrupts pain signals to the brain.

The claimant proved it is highly probable and free from serious doubt that the DIME physician, Dr. Gellrick, incorrectly apportioned the specific disorder impairment rating for the 2007 injury. The ALJ credits Dr. Ryan's testimony that Dr. Gellrick's apportionment based on the 2004 injury was predicated, in part, on her conclusion that in 2004 the claimant sustained injuries to his lumbar discs at three levels. Indeed, Dr. Gellrick stated in the DIME report that the claimant had, "pre-existing prior to the current injury, … documented injury of 2004, which demonstrated degenerative disc disease and disc protrusions at L3, L4 and L5." Dr. Ryan persuasively opined that the disc protrusions and facet arthropathy seen in the 2004 MRI were "red herrings," or purely incidental to the claimant's correct diagnosis of a sprain/strain injury. Dr. Ryan credibly explained that if

the claimant had actually injured the discs or facet joints in the 2004 injury, he would not have demonstrated such quick and complete recovery as he actually did. In this regard, the ALJ finds that Dr. Ryan's opinion that the claimant did not suffer any disc or facet injury is supported and corroborated by the reports of Dr. Brogmus, the physician that examined and treated the claimant for the 2004 injury. As recognized by Dr. Ryan, the reports of Dr. Brogmus do not contain evidence of radicular symptoms that might indicate a disc injury. Moreover, the treatment notes prepared by Dr. Brogmus show an overall course of improvement of the claimant's symptoms. Dr. Brogmus noted that by March 30, 2004, the date of MMI, the claimant was essentially pain free, was able to bend over and touch his toes, did not display any low back tenderness to palpation, and was able to perform his regular employment. More importantly, Dr. Brogmus, who personally examined the claimant, determined that he did not exhibit any ratable medical impairment caused by the 2004 injury.

The ALJ is also persuaded that the April 2007 industrial accident resulted in a new injury to the claimant's lumbar disc spaces that had not existed prior to that time. Dr. Ryan credibly explained that the results of the 2007 MRI were significantly different than the results of the 2004 MRI because the 2007 MRI revealed an L3-4 disc extrusion that was not present in 2004. Indeed, Dr. Benz considered this lesion operable, and surgery was performed to repair the disc on July 3, 2007. In his report of May 21, 2007, Dr. Benz credibly and persuasively corroborates Dr. Ryan's opinion that the claimant sustained a new disc injury in April 2007. For these reasons the ALJ rejects the HO respondents' assertion that Dr. Ryan "contradicted himself" in finding that the claimant did not sustain injury to his discs in 2004, but did sustain such injuries in 2007.

Dr. Gellrick also based her apportionment on a determination that the claimant's history "indicates a chronic back condition." The ALJ finds it is highly probable and free from serious doubt that after the claimant reached MMI for the 2004 injury he did not experience any chronic symptoms related to the 2004 injury. Therefore, it is highly probable that Dr. Gellrick was incorrect to base her apportionment on her mistaken understanding of the claimant's medical history following the 2004 injury. First, Dr. Gellrick's DIME report indicates her opinion is largely based on the contents of Dr. Basow's report of May 2, 2007, wherein Dr. Basow noted the claimant's history included a "chronic level of low back pain," and that the claimant denied any new injury after 2004. The ALJ credits the claimant's testimony that he falsified his history when he spoke to Dr. Basow on May 2, 2007, because he was afraid he would lose his job if he reported a new injury to HO, and because he needed new leads for his TENS unit to relieve pain that had developed after the April 2007 injury. The ALJ also notes that the precise meaning of the phrase "chronic level of low back pain" is not clear from Dr. Basow's report. Dr. Basow's May 2 note also states the claimant reported that he experienced acute "flare-ups" every three months and had experienced only minor back pain that did not require medical attention.

Moreover, the ALJ is persuaded it is highly probable that, although the claimant intermittently experienced back pain and stiffness after reaching MMI for the 2004 injury, those symptoms were not causally related to residual effects of the 2004 injury as Dr. Gellrick found. In this regard, the ALJ credits the claimant's testimony that he was able to

return to his relatively heavy work after reaching MMI, that most of his "flare-ups" occurred after a particularly heavy day's work, and that he was able to return to work the next day. Moreover, the claimant credibly testified that the symptoms he experienced during the flare-ups were similar to symptoms he noted before the 2004 injury. In his report of March 29, 2009, Dr. Ryan credibly opined that the claimant's ability to return to heavy work, his intermittent symptoms and lack of medical treatment were all factors indicating the claimant did not suffer any residual impairment from the 2004 injury. The ALJ infers from this evidence that the claimant's symptoms were most consistent with the ordinary aches and pains experienced by a truck driver who performs a relatively physical job, not the lingering effects of the 2004 injury. The claimant's testimony concerning the nature of these symptoms is corroborated by evidence that he did not challenge the FAL based on the 0 impairment rating issued by Dr. Brogmus, and he did not return to Dr. Brogmus for additional treatment after reaching MMI. Moreover, in the years between 2004 and 2007 the claimant sought treatment for his low back on only one occasion when he visited Dr. Whittemore for an "alignment" problem. During this same period of time the claimant was not reluctant to obtain chiropractic treatment for his neck and upper back on a relatively frequent basis.

The ALJ further finds that it is highly probable and free from serious doubt that Dr. Gellrick erred when she determined that the claimant exhibited 6 months of medically documented pain and rigidity sufficient to assess an impairment rating under Table 53 II (B). The ALJ credits Dr. Ryan's opinion that at the time Dr. Brogmus placed the claimant at MMI he was not exhibiting any pain or rigidity. Dr. Ryan credibly and persuasively opined that if the claimant was able to touch his toes and bend backwards he was not likely to be "rigid" as that term is used in the AMA Guides. Further, as recognized by Dr. Ryan, the claimant's symptoms were only intermittent after March 30, 2004, and even considering the brief flare-ups there is not sufficient medical documentation of 6 months of pain and rigidity before or after MMI. The documentary basis for Dr. Gellrick's contrary opinion, which relies principally on Dr. Basow's May 2, 2007, report of the claimant's history, is not persuasive for the reasons stated in Finding of Fact 33.

The ALJ further finds that Dr. Ryan's opinion that apportionment is not appropriate is corroborated and supported by the credible opinion of Dr. Thompson, the claimant's authorized treating physician. Dr. Thompson considered the issue of apportionment and expressly found that "none" is appropriate.

The ALJ finds it is more probably true than not that the claimant's impairment rating for the 2007 injury is 28 percent whole person, plus 1 percent for psychological impairment. Although the ALJ has found that Dr. Gellrick's apportionment was overcome by clear and convincing evidence, the ALJ finds that her rating is otherwise proper and correct. Dr. Gellrick's rating is corroborated by the opinion of Dr. Ryan who wrote that he agreed with Dr. Gellrick's approach to rating the claimant, except for her decision to apportion.

The claimant failed to prove it is more probably true than not that he sustained any worsening of condition proximately caused by the 2004 injury. As determined above, credible testimony and reports of Dr. Ryan, and the reports of Dr. Benz and Dr. Thompson establish that the claimant sustained a new injury in April 2007, and that injury

is the proximate cause of his subsequent need for treatment, disability and impairment. The claimant failed to produce any credible and persuasive evidence that he sustained a worsening of condition that was caused by the effects of the 2004 injury.

The claimant failed to prove it is more probably true than not that there was any “error” or “mistake” of law or fact that led to the closure of his claim for the 1994 injury. The weight of the evidence establishes that Dr. Brogmus correctly rated the claimant as having no permanent medical impairment caused by the 2004 injury. The ALJ credits the reports of and testimony of Dr. Ryan in this regard.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers’ Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Except as specifically noted below, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

OVERCOMING DIME PHYSICIAN ON APPORTIONMNET

The claimant argues that clear and convincing evidence proves Dr. Gellrick incorrectly apportioned the impairment rating for the 2007 injury based on residual impairment from the 2004 injury. The claimant argues that, contrary to Dr. Gellrick’s finding, the 2004 injury resulted in only a temporary strain/sprain that resolved by March 30, 2004, and did not cause any impairment. The claimant also argues that Dr. Gellrick

erred in finding that after the 2004 injury he demonstrated 6 months of medically documented pain and rigidity so as to justify a permanent impairment rating under Table 53 II(B) of the AMA Guides. The ALJ agrees with the claimant.

Section 8-42-104(2)(b), C.R.S. (recently amended with respect to injuries occurring on or after July 1, 2008) provides:

> Where benefits are awarded pursuant to §8-42-107, an award of benefits for an injury shall exclude any previous impairment to the same body part.

Under this version of § 8-42-104(2)(b), which is applicable to the claimant's April 2007 injury, apportionment of pre-existing medical impairment is one of the causation issues inherent in the DIME rating protocol. Consequently, the DIME physician's determination that a particular impairment is or is not subject to apportionment must be overcome by clear and convincing evidence. *Martinez v. Industrial Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Similarly, the DIME physician's application of the rating protocols contained in the AMA Guides to arrive at an apportionment decision must be overcome by clear and convincing evidence. *See McLane Western, Inc. v. Industrial Claim Appeals Office,* 996 P.2d 263 (Colo. App. 1999).

Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's apportionment must produce evidence showing it highly probable the DIME physician's determination is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

The AMA Guides provide that apportionment of medical impairment is appropriate only if the prior impairment has been sufficiently identified, treated, or evaluated to be rated as a contributing factor in any subsequent disability. Apportionment based on a pre-existing condition is not proper unless there is sufficient information to accurately measure the change in impairment. *Askew v. Industrial Claim Appeals Office,* 927 P.2d 1333, 1338 (Colo. 1996)*; Martinez v. Industrial Claim Appeals Office, supra*. Consistent with this principle WCRP 12-3 provides that a Level II physician shall apportion pre-existing medical impairment "where medical records or other objective evidence substantiate" the pre-existing impairment. Further WCRP 12-3 provides that any "apportionment shall be made by subtracting from the injured worker's impairment the pre-existing impairment as it existed at the time of the subsequent injury." Considering these principles, the ICAO has held that the DIME physician's determination of whether documentation of pre-existing impairment is or is not sufficient to support apportionment must ordinarily be overcome by clear and convincing evidence. *Hess v. Pinnacle Constructors & Specialties, Inc.,* W.C. No. 4-523-427 (ICAO August 15, 2003); *Campbell v. Department of Corrections,* W.C. No. 4-446-238 (ICAO, November 19, 2002).

The ALJ concludes the claimant proved it is highly probable and free from serious doubt that the 2004 injury did not cause any permanent impairment, but only a temporary strain/sprain that completely resolved by March 30, 2004. As determined in Finding of

Fact 31, the ALJ concludes that Dr. Gellrick erroneously found the 2004 injury caused injury to three disc levels that ultimately resulted in permanent impairment under Table 53 of the AMA Guides. The ALJ has credited the persuasive and credible opinion of Dr. Ryan that the claimant did not actually sustain any disc injuries in 2004, but instead suffered a strain/sprain that fully resolved by March 30, 2004, when Dr. Brogmus placed the claimant at MMI without impairment. Moreover, as determined in Finding of Fact 32, the ALJ is persuaded that the claimant sustained a new injury in April 2007 as evidenced by the ruptured disc at L3-4. This finding is supported by the credible opinions of Dr. Ryan and Dr. Benz.

The ALJ further concludes that it is highly probable that Dr. Gellrick incorrectly based her apportionment on the conclusion that after being placed at MMI for the 2004 injury the claimant had a significant history of "chronic back pain" caused by that injury injury. As determined in Finding of Fact 33, Dr. Gellrick's reliance on Dr. Basow's report of May 2, 2007, as the basis for her opinion that the claimant had "chronic back pain" is misplaced. First, the ALJ has determined the claimant deliberately misrepresented his history to Dr. Basow so as to procure leads for the TENS unit and to avoid the necessity of filing a claim against HO for the 2007 injury. Further, the meaning of Dr. Basow's statement that the claimant had a history of "chronic back pain" is unclear considering that he also stated the claimant experienced "flare-ups" every three months and had only minor back pain that did not require treatment. Moreover, as determined in Finding of Fact 34, it is highly probable that the symptoms the claimant exhibited after being placed at MMI in March 2004 were not caused by the 2004 injury, but instead represented the ordinary aches and pains experienced by a person performing the same type of work as the claimant.

Finally the ALJ concludes it highly probable and free from serious doubt that Dr. Gellrick erred in finding that as a result of the 2004 injury the claimant sustained 6 months of medically documented pain and rigidity that would justify assignment of impairment under Table 53 II(B) of the AMA Guides. As determined in Finding of Fact 35, the claimant did not exhibit lumbar pain or rigidity at the time he was placed at MMI in March 2004, less than 4 months after the date of injury. Moreover, although the claimant exhibited some low back symptoms after March 30, 2004, those symptoms were of brief and intermittent occurrence, and do not amount to 6 months of documented pain. The ALJ is persuaded by the opinion of Dr. Ryan that the medical records do not document 6 months of pain and rigidity after the 2004 injury so as to justify an impairment rating under Table 53 II(B).

DETERMINATION OF CLAIMANT'S IMPAIRMENT RATING

Having determined that the claimant overcame Dr. Gellrick's impairment rating by clear and convincing evidence, it is necessary to determine the claimant's actual impairment rating for purposes of the award of permanent partial disability benefits.

In *Deleon v. Whole Foods Market, Inc.,* W.C. No. 4-600-477 (ICAO November 16, 2006), the Industrial Claim Appeals Office addressed the proper evidentiary standard for determining a claimant's impairment rating in cases where an ALJ finds that some portion

of a DIME physician's impairment rating has been overcome by clear and convincing evidence. The ALJ in the *Deleon* case found that the respondents overcame by clear and convincing evidence a DIME physician's finding that the claimant sustained 5 percent impairment for lost range of motion in the lumbar spine. However, the ALJ also found that the respondents failed to overcome by clear and convincing evidence the DIME physician's finding that the claimant sustained 5 percent impairment for a specific disorder of the lumbar spine. Thus, the ALJ upheld the specific disorder portion of the DIME physician's rating under the clear and convincing standard. However, the ICAO ruled that once an ALJ determines "the DIME's rating has been overcome in any respect" the ALJ is "free to calculate the claimant's impairment rating based upon the preponderance of the evidence" standard. The ICAO further stated that when applying the preponderance of the evidence standard the ALJ is "not required to dissect the overall impairment rating into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence." Because the *Deleon* case represents the most direct and compelling authority concerning this issue, the ALJ finds it persuasive and will apply the panel's analysis in this case. *See also Ortiz v. Service Experts, Inc.,* W.C. No. 4-657-974 ICAO January 22, 2009) (favorably citing *Deleon*).

As determined in Finding of Fact 37, the ALJ concludes that a preponderance of the evidence establishes the claimant's impairment rating for the 2007 injury is 28 percent whole person, plus an additional 1 percent for psychological impairment. This finding is based on Dr. Gellrick's rating without regard to apportionment. The ALJ finds that Dr. Ryan corroborated Dr. Gellrick's rating except for her decision to apportion.

REOPENING 2004 CLAIM BASED ON CHANGE OF CONDITION

The claimant argued that the claim for the 2004 injury should be reopened based on a worsened condition. The ALJ understands from the claimant's position statement that this is an "alternative theory" of the case since the claimant's actual view of the evidence is that he sustained a new injury in 2007 that is the cause of all of his impairment. As reflected in this order the ALJ agrees with the claimant's primary theory; therefore the ALJ denies petition to reopen the 2004 injury based on a worsened condition.

Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. The claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985).

The question of whether the claimant met the burden of proof to establish a causal relationship between the industrial injury and the worsened condition is one of fact for

determination by the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *City of Durango v. Dunagan, supra.* Similarly, the question of whether the disability and need for treatment were caused by the industrial injury or by an intervening cause is a question of fact. *Owens v. Industrial Claim Appeals Office,* 49 P.3d 1187 (Colo. App. 2002).

As determined in Finding of Fact 38, the claimant failed to prove that he sustained any worsening of condition caused by the 2004 injury. Rather, the evidence establishes that the claimant sustained a new injury in 2007, and that the 2007 injury was the cause of the claimant's subsequent disability and need for treatment. The petition to reopen the 2004 claim based on change of condition must be denied.

REOPENING 2004 CLAIM BASED ON ERROR OR MISTAKE

The claimant also argued that the claim for the 2004 injury should be reopened based on error or mistake. Apparently, the basis of this argument is that closure of the 2004 claim was based on the erroneous determination that the claimant did not sustain any permanent medical impairment resulting from the 2004 injury. Again, the ALJ understands from the claimant's position statement that this is an "alternative theory" of the case. The ALJ concludes there was no mistake with respect to the 2004 injury.

An "award" may be reopened on the grounds of "error" or "mistake." Section 8-43-303(1), C.R.S. The party seeking to reopen bears the burden of proof to establish grounds to reopen. *See Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000).

The terms "error" and "mistake" refer to any mistake whether one of law or fact. *Renz v. Larimer County School District Poudre R-1,* 924 P.2d 1177 (Colo. App. 1996). The authority to reopen is discretionary provided the statutory criteria have been met. *Berg v. Industrial Claim Appeals Office, supra*. In order to reopen based on error or mistake the ALJ must determine that there was an error or mistake that affected the prior award. If there was a mistake the ALJ must determine whether, under the circumstances, it is the type of mistake that justifies reopening the claim. *Travelers Insurance Co. v. Industrial Commission,* 646 P.2d 399 (Colo. App. 1981).

As determined in Finding of Fact 39, the claimant failed to prove there was any error or mistake that led to closure of the 2004 claim for benefits. To the contrary, the weight of the evidence establishes that Dr. Brogmus correctly determined the claimant did not sustain any permanent impairment causally related to the 2004 industrial injury, and that the MI respondents properly filed an FAL closing the claim without admitting for any permanent disability benefits. The petition to reopen based on error mistake must be denied.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. In W.C. No. 4-724-582 the insurer for HO shall pay permanent partial disability benefits based on Dr. Gellrick's total impairment rating *without regard to any apportionment.*

2. The petition to reopen W.C. No. 4-601-476 on grounds of change of condition, error and mistake is denied and dismissed.

3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due, if any.

4. All matters not determined by this order are reserved for future determination.

DATED: July 13, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-711-456

ISSUES

The issues determined herein are disfigurement benefits and an offset for short-term disability ("STD") benefits. The parties stipulated that claimant's average weekly wage was $498.82.

FINDINGS OF FACT

1. Claimant suffered an admitted industrial injury on December 28, 2006.

2. Claimant ceased employment with the employer and began work for United HealthCare Services, Inc.

3. On November 4, 2008, Dr. Jenks excused claimant from work. Claimant underwent a cervical fusion surgery on November 25, 2008.

4. On December 16, 2008, claimant returned to work for United HealthCare Services, Inc.

5. While off work, claimant received $1,471.16 in STD benefits from a policy provided by United HealthCare Services, Inc. The subsequent employer listed the STD benefits as "wages" during each two-week pay period and withheld taxes on those benefits. The subsequent employer continued to provide $24 in fringe benefits during

each pay period. The record evidence does not identify these fringe benefits. The employer at the time of injury did not contribute to the STD benefit policy.

6. On April 7, 2009, the insurer filed a General Admission of Liability for temporary partial disability ("TPD") benefits in the total amount of $617.52 for the period November 4 through December 12, 2008. The insurer deducted all of the STD benefits as "wages" for the calculation of TPD benefits.

7. Claimant suffered a serious and permanent bodily disfigurement normally exposed to public view in the form of a two-inch, thin, red and white scar on the anterior neck.

CONCLUSIONS OF LAW

1. Section §8-42-103(1)(d)(I) C.R.S., provides that, in cases where disability benefits are payable to an employee under a disability plan financed in whole or in part by the employer the aggregate benefits payable for temporary or permanent disability shall be reduced by the amount of the STD benefits. If the employee contributes to the disability plan, the workers' compensation benefits are reduced only in proportion to the percentage paid by the employer. Section 8-42-103(1)(d)(I)(A), C.R.S. Claimant argues that this specific section dealing with offset for STD benefits controls in this case.

2. Respondents ignore the specific STD offset provisions and argue that the STD benefits are "wages" for purposes of calculating TPD benefits. Wages are defined by §8-40-201(19)(a), C.R.S., as the "money rate at which the services rendered are recompensed under the contract of hire in force at the time of the injury, either express or implied." Admittedly, the wages earned from subsequent employers are used to calculate the TPD benefits pursuant to section 8-42-106, C.R.S.

3. Nevertheless, claimant is correct that the specific statutory provision for calculation of the STD offset controls in this case. The general assembly provided a very specific statute for the offset. The insurer does not get to deduct STD benefits unless the insured employer contributed to the STD benefit and the offset is only to the percentage of the employer's contribution. The purpose of the offset is to prevent a double recovery of disability benefits where an employer purchased both workers' compensation insurance and disability benefits for the benefit of the employee. *Myers v. State,* 162 Colo. 435, 428 P.2d 83 (1967); *Spanish Peaks Mental Health Center v. Huffaker,* 928 P. 2d 741 (Colo. App. 1996); *Durocher v. Industrial Claim Appeals Office,* 905 P.2d 4 (Colo. App. 1995), *aff'd. on other issues,* 919 P.2d 246 (Colo. 1996). In this case, the employer did not contribute to the STD benefit. Consequently, respondents are not entitled to any offset for the STD benefits. The subsequent employer's classification of the STD benefits as "wages" is not determinative of this insurer's right to deduct those benefits from the worker's compensation benefits owed to claimant.

4. Because claimant had no wages during the period of disability, she is entitled to temporary total disability ("TTD") benefits pursuant to section 8-42-105, C.R.S.,

at the rate of $332.55 per week for all admitted periods of time. The insurer admitted liability only through December 12, 2008, although the parties appear to agree that claimant was disabled through December 15, 2008. That issue was not litigated and is not addressed herein.

5. Pursuant to section 8-42-108, C.R.S. (2006), claimant is entitled to up to $2,000 for a serious and permanent bodily disfigurement normally exposed to public view. Considering the size, location, and general appearance of the disfigurement, the Judge concludes that claimant is entitled to the maximum award of $2,000.

ORDER

It is therefore ordered that:

1. The insurer shall pay to claimant TTD benefits at the rate of $332.55 per week for all admitted periods of time. The insurer is entitled to an offset for TPD benefits previously paid to claimant for the same time periods.

2. The insurer shall pay to claimant $2,000 in one lump sum for bodily disfigurement benefits.

3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

4. All matters not determined herein are reserved for future determination.

DATED: July 14, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-785-492

ISSUES

The issue determined herein is compensability. The parties stipulated to medical benefits.

FINDINGS OF FACT

1. In October 2008, claimant began work as a paraprofessional for the Employer. Her primary job duties involved providing one-on-one assistance with a special-needs, autistic child. From time to time the child experiences “autistic meltdowns,” during which he becomes excessively vocal and engages in a “kicking” type motion for self-stimulation.

2. When the child experiences an “autistic meltdown,” the Claimant generally removes him from the regular classroom setting and takes him to a separate room connected to the “resource room.”

3. On January 26, 2009, the child experienced an “autistic meltdown” and the Claimant took him to the separate room. The child threw himself down on a bean bag chair and began the kicking motion.

4. As the Claimant stood near the child and attempted to calm him down, the child kicked the medial aspect of the Claimant’s left knee. She experienced a varus stress with a popping sensation and pain in the knee.

5. The Claimant reported the incident to a supervisor the day it occurred, but did not immediately request medical care because she did not yet know the extent of the injury.

6. The Claimant’s knee became increasing swollen and painful over the next two days.

7. On January 28, 2009, the Claimant formally requested that the Employer provide her with medical treatment. An Employer’s First Report of Injury was completed and the Claimant was referred to the Memorial Occupational Health Clinic.

8. On January 30, 2009, Dr. Castrejon at Memorial Occupational Health Clinic examined claimant, who reported to Dr. Castrejon that the injury occurred when she was kicked in the side of the knee by a child having an autistic meltdown. She further reported that, since the injury, she had experienced limping, swelling, and a sensation of weakness and giving way. Dr. Castrejon diagnosed a left knee strain and referred Claimant for a magnetic resonance image (“MRI”) of the left knee.

9. The February 9, 2009, MRI revealed a torn anterior cruciate ligament (ACL), suspected tearing of the medial meniscus, and osteoarthritis in the medial compartment.

10. In light of the MRI and exam findings, Dr. Castrejon referred Claimant to Dr. Pak for surgical evaluation.

11. On February 10, 2009, Dr. Zakaria, at Memorial Occupational Health Clinic, examined claimant, who reported some increased pain after “running” after a child that day.

12. Claimant was evaluated by Dr. Pak on February 13, 2009. Dr. Pak diagnosed a traumatic ACL tear with instability and recommended reconstructive surgery. He also noted arthritic changes in the medial compartment.

13. Claimant suffered a previous non-industrial left knee meniscal injury, for which she had surgery in 2005. She had some continuing pain, but received no medical treatment after October 2006. She had intermittent left knee pain due to arthritis, but she did not have an ACL tear. In the fall of 2008, after starting work for the employer, claimant occasionally limped on her left leg.

14. On approximately February 17, 2009, Claimant attempted to get out of the passenger side of her car at home. Her left knee buckled. She grabbed the door frame with her left hand, but fell to the ground, injuring her left shoulder.

15. On February 19, 2009, Dr. Zakaria examined claimant, who reported a history of the fall onto her left side, injuring the shoulder.

16. On February 23, 2009, claimant sought treatment at Memorial Health System Urgent Care, providing a history of falling six days earlier when her left knee gave out.

17. Dr. Castrejon subsequently concluded that claimant sustained a work related injury to the left arm as a result of her left knee buckling.

18. Dr. Castrejon referred the Claimant for physical therapy for the left shoulder. The shoulder symptoms continued to worsen despite therapy.

19. On April 3, 2009, Dr. Castrejon recommended a MRI of the left shoulder due to persistent shoulder pain, decreased function, and inability to progress further with therapy. The Insurer denied authorization for the shoulder MRI.

20. On May 20, 2009, Dr. Ridings performed an independent medical examination for respondents. Dr. Ridings concluded that the Claimant suffered a torn ACL as a result of the January 26, 2009 accident. Dr. Ridings further opined that the torn ACL caused instability of the knee, which caused the Claimant to fall in February 2009. Dr. Ridings concluded that, as a consequence of the fall, Claimant likely developed impingement syndrome and myofascial pain in the musculature around the left shoulder. He considered the knee and shoulder conditions to be work-related. Dr. Ridings agreed with Dr. Pak’s recommendation for surgery on the left knee, and agreed that Claimant should have an MRI of the left shoulder.

21. Claimant has proven by a preponderance of the evidence that she suffered an accidental injury to her left knee arising out of and in the course of her employment on January 26, 2009. Claimant suffered previous left knee meniscal injury, for which she had surgery in 2005. She had some continuing pain, but received no medical treatment after October 2006. She had intermittent left knee pain due to arthritis, but she did not have an ACL tear. The autistic child's kick to the left knee probably caused the ACL tear. Claimant has provided a consistent history of the injury to all medical providers. Claimant's testimony regarding her history and the course of the January 26, 2009 injury is credible. Claimant already had the ACL tear before the "running" incident on February 10, 2009. As a natural consequence of the accidental injury to the left knee, claimant fell on approximately February 17, 2009, suffering a left shoulder injury. Claimant promptly reported the knee injury within two days. She gave a consistent history to medical providers. Even Dr. Ridings concluded that claimant's left knee and left shoulder injuries were compensable.

CONCLUSIONS OF LAW

Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). In determining credibility, the Judge should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or evidence, and any bias, prejudice or interest in the outcome of the case. *Colorado Jury Instructions, Civil*, 3:16. As found, Claimant has proven by a preponderance of the evidence that she suffered an accidental injury to her left knee arising out of and in the course of her employment on January 26, 2009. As found, as a natural consequence of the accidental injury to the left knee, claimant fell on approximately February 17, 2009, suffering a left shoulder injury.

ORDER

It is therefore ordered that:

10. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers, including Dr. Castrejon, Dr. Pak, the urgent care facility, as well as the provision of left knee surgery and a left shoulder MRI.

11. All matters not determined herein are reserved for future determination

DATED: July 14, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-740

ISSUES

This case comes before the Court on the following issue:

1. Authorization of and payment to Dr. O'Donnell and his referrals.

FINDINGS OF FACT

1. Claimant alleged an injury to his low back while working for the Respondent-Employer in early April 2008. The injury was found compensable by ALJ Stuber in a Summary Order dated January 2, 2009. Specific Findings dated January 14, 2009 were entered. Judge Stuber granted a general award of medical benefits, but specific medical benefits were not "requested and none" were ordered.

2. Claimant's first unequivocal report of a work injury to the Respondent-Employer occurred after private automobile insurer indicated to Claimant on May 8, 2008 that his low back complaints would not be authorized under a non-work related October 2007 MVA. Prior to the private insurer not authorizing care for the non-work related October 2007 MVA, Claimant sought medical treatment through his personal physician, Dr. O'Donnell, and his problems were attributed to the October 2007 non-work related MVA. Dr. O'Donnell made referrals to other medical providers, ordered an x-ray and requested an MRI. Claimant seeks an order requiring respondents to pay for the treatment rendered by Dr. O'Donnell and his referrals.

3. Dr. O'Donnell was not an ATP; Dr. O'Donnell was Claimant's personal physician. Moreover, Dr. O'Donnell crafted his treatment plan and rendered care during the time when Claimant pursued treatment of his low back under his health insurance and under an October 2007 motor vehicle accident unrelated to his work. The care provided to Claimant by Dr. O'Donnell and his referrals was authorized under his health insurance. The care provided to Claimant was pursued under the private insurer MVA claim. When the private insurer denied the care, Claimant pursued a worker's compensation claim. Prior to that time, the care was undeniably pursued under a non-work related MVA claim.

4. Claimant did not recognize the work related nature of his low back pain prior to the denial of care by his private insurer for the non-work related October 2007 MVA.

5. While Claimant was pursuing this claim under the October 2007 non-work related MVA, the three medical providers Claimant asks Respondent-Insurer be required to pay all reported in their records that Claimant's treatment was related to his October 2007 MVA.

6. The evidence shows that it is more likely than not that the treatment Claimant wants authorized and paid for was generated by Claimant's assertions of a non-work related injury.

7. Claimant asserted to Dr. O'Donnell and his referrals that the treatment requested was the result of a non-work related MVA covered by private insurance. Those assertions – contained in the records of Dr. O'Donnell, Dr. Knoche, the private insurer, and the radiology staff of Memorial Hospital – are consistent with the understanding of Claimant's supervisor, Chris Akerlund; Claimant did not know what caused his low back pain, but believed it could be related to his non-work related MVA in October 2007.

CONCLUSIONS OF LAW

1. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either Claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

2. In determining credibility, the ALJ should consider the witness' manner and demeanor on the stand, means of knowledge, strength of memory, opportunity for observation, consistency or inconsistency of testimony and actions, reasonableness or unreasonableness of testimony and actions, the probability or improbability of testimony and actions, the motives of the witness, whether the testimony has been contradicted by other witnesses or

evidence, and any bias, prejudice or interest in the outcome of the case. *COLORADO JURY INSTRUCTIONS, CIVIL*, 3:16.

3. An employer is not responsible for medical expenses incurred by the Claimant before the Claimant gives the employer notice of a work related injury. *Picket v. Colorado State Hospital*, 513 P.2d 228 (1973). See also *Bunch v ICAO, Dow Chemical Company, and travelers Property and Casualty Company*, 148 P. 3d 381 (Colo. App. 2006.) This long standing rule derives from the fact that an employer or insurer has the right to select Claimant's treating physician in the first instance. Section 8-43-404(5). As the ICAO stated in *Anderson v. Tri Centennial Corporation*, W.C. No. 3-902-259 (February 1990), "it follows that an employer is not liable for the medical expenses incurred by an injured worker prior to the time that it has notice of the injury." See also *Lopez v. Stresscon Corporation*, W.C. Nos. 4-198-942 and 4-198-942 and 4-198-943 (October 1995), and *Zapiecki v. Exabyte Corporation, and Pinnacol Assurance and/or Argonaut Insurance*, W.C. No. 4-539-081 (January 2004). The employer's duty is triggered once the employer or insurer has some knowledge of facts that would lead a reasonably conscientious manager to believe the case may involve a claim for compensation. *Bunch v. Industrial Claim Appeals Office of State of Colorado*, 148 P.3d 381 (Colo. App. 2006); *Jones v. Adolph Coors Co*., 689 P.2d 681 (Colo. App. 1984).

4. A reasonably conscientious manager would not have believed Claimant was asserting a claim for worker's compensation prior to his private insurer denying the claim on May 8, 2008. Through May 8, 2008, Claimant asserted to the very providers he now believes should be deemed authorized that his back problems were related to an October 2007 MVA, not work. When asked about the source of his back problems, Claimant told his manager that it was related to the October 2007 MVA. Claimant asserted to his private insurer, the carrier for the October 2007 MVA that it was related to the MVA and never mentioned any work injury.

5. Claimant's positive assertions to all involved prior to the denial of his MVA claim was that the back pain was related to the MVA. The evidence from the private insurer and medical providers supports Mr. Akerlund's testimony that he thought Claimant was asserting the back pain was related to the MVA, not work, when Claimant first mentioned he had back pain.

ORDER

It is therefore ordered that:

Claimant's claim to have medical treatment provided by Dr. O'Donnell and his referrals authorized and paid for by the Respondent-Insurer is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATE: July 15, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-540-676

PROCEDURAL HISTORY

On August 13, 2008, claimant filed an Application for Hearing, seeking a hearing on his Petition to Reopen his claim for Permanent Total Disability benefits. Respondents filed a Response to Application for Hearing on August 20, 2008, raising a number of affirmative defenses, including a statute of limitations defense.

At the close of claimant's evidence in his case-in-chief, respondents moved to dismiss claimant's Petition to Reopen under C.R.C.P. 41(b)(1). Respondents argued that claimant's Petition to Reopen is time-barred by §8-43-303, C.R.S. (2008). The Judge granted respondents' motion to dismiss.

ISSUES

- Did respondents prove by a preponderance of the evidence that claimant's Petition to Reopen his claim is time-barred?

- Did claimant carry the burden of establishing by a preponderance of the evidence the factual foundation to equitably toll the statute of limitations for filing his Petition to Reopen?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

16. Employer operates a public utility that provides electric power to customers. Claimant's date of birth is April 12, 1949; his age at the time of hearing was 59 years. Claimant worked for employer from 1982 until May 31, 2005, when he terminated his employment and began receiving long-term disability benefits.

17. Claimant suffered a work-related injury to his lower back on August 22, 2001. R. James McLaughlin, M.D., is an authorized treating physician

(ATP). Dr. McLaughlin diagnosed a lumbar strain, with degenerative joint disease, and placed claimant at maximum medical improvement (MMI) on May 3, 2002. Dr. McLaughlin rated claimant's permanent medical impairment at 7% of the whole person, after apportionment.

18. Insurer filed a Final Admission of Liability (FAL) on May 13, 2002, admitting liability for permanent partial disability (PPD) benefits in the amount of $20,619.04 based upon Dr. McLaughlin's 7% rating. Insurer paid claimant the $20,619.04 sum at a weekly rate of $354.91 over the period of time from May 3, 2002, through June 12, 2003. By providing claimant a copy of the May 13, 2002, FAL, insurer revealed to claimant the nature of the award as PPD benefits and the time period over which it would pay those benefits. By virtue of the May 13, 2002, FAL, claimant knew or should have known insurer was paying him PPD benefits through June 12, 2003, based upon Dr. McLaughlin's 7% rating. Insurer's indemnity payment print-out (Respondents' Exhibit K) shows that insurer issued claimant the final payment of the $20,619.04 in PPD benefits by check dated June 11, 2003. Claimant failed to object to the May 13, 2002, FAL. Claimant's claim closed by operation of law.

19. Based upon a recommendation for additional curative treatment, respondents voluntarily agreed to reopen claimant's claim for additional medical benefits. On May 5, 2004, insurer filed a General Admission of Liability, admitting liability only for additional medical benefits.

20. Dr. McLaughlin subsequently placed claimant back at MMI as of October 21, 2004. Dr. McLaughlin determined that claimant's permanent medical impairment had increased by an additional 3% of the whole person. On December 22, 2004, insurer filed a FAL, admitting liability for additional PPD benefits.

21. The Division of Workers' Compensation (division) issued a letter on January 7, 2005, disagreeing with insurer's calculation of claimant's PPD award and directing insurer to file a revised FAL.

22. Insurer filed a revised FAL on January 26, 2005, admitting liability for PPD benefits consistent with the division's calculation. In the revised FAL, insurer showed that it had previously paid in full claimant's prior PPD award of $20,619.04, which was based upon Dr. McLaughlin's initial rating of 7% of the whole person. Insurer also shows its calculation of claimant's additional award of PPD benefits in the amount of $8,526.67, which was based upon Dr. McLaughlin's 3% whole person rating. Insurer's revised FAL further reflects an admission for claimant's total award of PPD benefits in the amount of $29,145.71 ($20,619.04 + $8,526.67 = $29,145.71), representing an award based upon impairment of 10% of the whole person.

23. The Benefit History section of the revised FAL however incorrectly reflects the payment history of the overall PPD award of $29,145.71. The Benefit History section of the revised FAL fails to reflect that insurer had previously paid the prior PPD award in the amount of $20,619.04 at the weekly rate of $354.91 from May 3, 2002, through June 12, 2003. The Benefit History section of the revised FAL incorrectly shows payment of the overall PPD award of $29,145.71 at the weekly rate of $354.91, running from the second MMI date of October 21, 2004, through May 17, 2006.

24. Under the revised FAL, insurer actually owed claimant additional PPD benefits in the amount of $8,256.67, not in the amount of $29,145.71. At the weekly rate of $354.91, insurer paid out the PPD award of $8,256.67 over a period of twenty-four weeks and two days, from the MMI date of October 21, 2004, through April 8, 2005. Crediting insurer's indemnity payment print-out (Respondents' Exhibit K), insurer issued the final payment of the $8,256.67 by check or about April 13, 2005.

25. On December 7, 2007, claimant filed his Petition to Reopen, alleging a change in condition and error or mistake. Claimant supported his Petition to Reopen with a December 3, 2007, report from Psychiatrist Kenneth D. Krause, M.D.

26. Claimant filed his December 7, 2007, Petition to Reopen 6 years and 108 days after his date of injury of August 22, 2001. December 7, 2007, is 2 years and 209 days after April 13, 2005, the last date claimant's PPD benefits became due or payable.

27. Based upon the May 13, 2002, FAL, insurer was legally obligated to pay claimant the prior PPD award at that time based upon Dr. McLaughlin's initial rating of 7% of the whole person. Claimant failed to present any persuasive evidence showing he was unaware that the $20,619.04 represented a PPD award or that he was unaware that his PPD award increased by 3% after insurer voluntarily agreed to reopen his case for additional treatment and for additional PPD benefits.

28. Claimant failed to show it more probably true than not that he was prejudiced or otherwise relied to his detriment on the incorrect Benefit History section of the revised FAL of January 26, 2005. Because insurer was legally obligated to pay claimant the PPD award of $20,619.04 by June 12, 2003, there was no evidentiary basis to infer that insurer intended to prejudice claimant by paying him those benefits. As found, because of information insurer revealed in the May 13, 2002, FAL, claimant knew or should have known insurer was paying him PPD benefits through June 12, 2003, based upon Dr. McLaughlin's 7% rating. Although claimant's claim closed by operation of law after he failed to object to the May 13, 2002, FAL, insurer voluntarily agreed to reopen claimant's claim for additional medical treatment, and later for an additional PPD award of 3%. This

course of dealing fails to provide any evidentiary basis to infer that insurer intended to prejudice claimant when it filed the revised FAL. Claimant offered no persuasive testimony or other evidence showing that he relied on the information contained in the Benefit History section in deciding when to file his Petition to Reopen or in deciding to delay its filing until December 7, 2007. Claimant presented no persuasive testimony or other evidence to establish that he was unaware that his PPD benefits ended with the final payment on April 13, 2005, instead of continuing for another year until May 17, 2006. Claimant thus failed to carry his burden of establishing by a preponderance of the evidence the factual foundation to equitably toll the statute of limitations for filing his Petition to Reopen.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

A. Application of Statutory Limitations on Reopening:

Respondents argue they have proven by a preponderance of the evidence that claimant's petition to reopen his claim is time-barred under the provisions of §8-43-303. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Section 8-43-303(1), *supra*, provides:

> At any time **within six years after the date of injury**, the director or an administrative law judge may … review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition ….

Section 8-43-303(2)(a), *supra*, further provides:

> At any time **within two years after the date the last** temporary or **permanent disability benefits** … excluding medical **benefits become due or payable**, the director or administrative law judge may … review and reopen an award on the ground of … an error, a mistake, or a change in condition ….

(Emphasis added).

Here, the Judge found claimant filed his Petition to Reopen on December 7, 2007. Claimant filed his Petition to Reopen 6 years and 108 days after his date of injury of August 22, 2001, and 2 years and 209 days after April 13, 2005, the last date claimant's PPD benefits became due or payable. Claimant filed his Petition to Reopen outside the time limits allowed under §§8-43-303(1) and (2)(a). Respondents thus proved by a preponderance of the evidence that claimant's Petition to Reopen is time-barred, such that the Judge lacks jurisdiction to reopen claimant's claim.

B. Equitable Tolling of Reopening Statute:

Claimant argues he has proven by a preponderance of the evidence an equitable basis for tolling the statute of limitations for filing his Petition to Reopen. The Judge disagrees.

"The application of the equitable tolling doctrine requires certain factual determinations." *Garret v. Arrowhead Improvement Ass'n*, 826, P.2d 850, 855 (Colo. 1992). A court may apply equitable principles to toll a statute of limitations where a party fails to disclose information he is legally required to reveal and the other party is prejudiced thereby. *Id*. However, claimant "must bear the burden of establishing the factual foundation for equitably tolling the statute of limitations." *Id.* Such a factual foundation could consist of persuasive evidence or testimony in the record that claimant reasonably relied on the incorrect Benefit History section of the FAL.

Here, the Judge found claimant failed to show it more probably true than not that he was prejudiced or otherwise relied to his detriment on the incorrect Benefit History section of the revised FAL of January 26, 2005. Claimant thus failed to carry his burden of establishing by a preponderance of the evidence the factual foundation sufficient to equitably toll the statute of limitations for filing his Petition to Reopen.

Although insurer's January 26, 2005, revised FAL incorrectly states the PPD period as running through May 17, 2006, claimant presented no persuasive evidence to show that he was prejudiced or reasonably relied to his detriment on the incorrect Benefit History section of the revised FAL in deciding when to file his Petition to Reopen. Because of information insurer revealed in the May 13, 2002, FAL, the Judge found that claimant knew or should have known insurer was paying him PPD benefits through June 12, 2003, based upon Dr. McLaughlin's 7% rating. In light of this finding, even if claimant relied upon the revised FAL, such reliance would have been unreasonable.

Finally, claimant's counsel raised his reliance on the incorrect FAL in counsel's argument, but there was no persuasive testimony or evidence in the record to demonstrate that claimant himself relied on the incorrect FAL in deciding when to file his Petition to Reopen. As found, the actual date that claimant's PPD benefits became due or payable was April 13, 2005. Claimant presented no persuasive testimony or other evidence to establish that he was unaware that his PPD benefits ended with the final payment on April 13, 2005, instead of continuing for another year until May 17, 2006. Thus, the Judge found that claimant failed to present persuasive evidence or testimony required to establish the factual foundation to equitably toll the statute of limitations governing the time within which to file his Petition to Reopen.

The Judge concludes that claimant's December 7, 2007, Petition to Reopen should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's December 7, 2007, Petition to Reopen is denied and dismissed, with prejudice.

2. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _July 15, 2009

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-733-392

ISSUES

- Was the claimant an employee of the employer on the date of injury, or was he an independent contractor?
- Did the claimant prove by a preponderance of the evidence that he sustained an injury arising out of and in the course of his alleged employment?
- Did the claimant prove by a preponderance of the evidence that he is entitled to medical treatment as a result of the alleged industrial injury?
- Did the claimant prove by a preponderance of the evidence that he is entitled to temporary total disability benefits as a result of the alleged industrial injury?
- What is the claimant's average weekly wage?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

The employer is a general contractor that constructs framing for large apartment complexes. The employer has been engaged in this business for approximately twenty

years. The employer has a workers' compensation policy with the insurer. This policy covers only two employees, the office manager and a superintendent.

The employer obtains projects by submitting bids to a general contractor. Generally, the projects are for large apartment buildings of 200 to 300 units. If the employer's bid is accepted the employer is responsible for all the interior and exterior rough framing, and preparing for the siding and roofing companies to come in and complete their portions of the project.

The claimant was born in Guatemala and came to the United States in 1979. Since then he has made trips back and forth between the two countries. The claimant's native language is Spanish, but he can read and write a very limited amount of English. He can also speak limited English. He can request simple things, such as food. He also understands the terms he needs to know to work in construction as a carpenter.

The claimant worked as a carpenter for many years before he worked for the employer. The claimant first performed carpentry services for the employer in approximately 2000. At that time the employer did not require the claimant to use a "company name" in order to work and receive pay. However, the claimant credibly testified that in 2001 the employer "changed the rules" so as to require all workers to obtain a "company name" if they wished to continue working for the employer. The ALJ finds the claimant's testimony is corroborated by the credible testimony of Mr. Elias Rodriguez and Mr. Jose Roberto Rivas, coworkers of the claimant who are familiar with the employer's hiring policies.

In order to continue his relationship with the employer, the claimant adopted the "company name" of Michelle Construction.

Between 2001 and 2007, the claimant sometimes performed services for the employer and sometimes worked for other contracting entities. In 2007 the claimant, in addition to working for the employer, performed services for J.E. Dunn and received a W-2 reflecting that he was paid in his own name. In 2006, the claimant, in addition to working for the employer, performed services for Newstrom Davis and received a W-2 reflecting that he was paid in his own name. In 2004, in addition to working for the employer, the claimant worked for Nail It Construction and received a 1099 reflecting that he was paid in his own name. In 2003, the claimant in addition to working for the employer, worked for SLI Framing and received a 1099 reflecting that he was paid in his own name. The claimant also worked for Nail It Construction 2003 and received a 1099 listing the "recipient" as the claimant in his own name and Michelle Construction. The ALJ infers from this evidence that as a general rule between 2001 and 2007 the claimant, except when working for the employer, used and was paid in his own name.

On June 6, 2007, the claimant and the employer's president, William Piranian, had a meeting in which the employer retained the claimant's services to perform "punch and back out" carpentry services on a large apartment construction project. In the course of this meeting the claimant executed a document captioned Declaration of Independent Contractor Status (DICS). The claimant also executed a document entitled Subcontractor Agreement (SA). These documents are both printed in English and there is no credible

or persuasive evidence that the claimant was ever provided translated copies of the documents written in the Spanish language.

The DICS contains an express statement, written in English, that the employer does not require, perform or dictate any of the conditions of employment or other circumstances contained in § 8-40-202(2)(b)(II)(A) through (I), C.R.S. The claimant placed his initials beside each of these nine criteria, as did Mr. Piranian. The DICS also contains a statement in bold print that the "independent contractor" understands that he is not entitled to workers compensation in the event of injury.

The SA states that the "subcontractor" will provide general liability insurance and provide the employer with evidence of a registered trade name. The SA further provides that if liability and workers' compensation insurance are not provided the employer will charge "up to 25% to cover the cost of this insurance."

The claimant testified that when he was presented with the DICS he could not read it and did not understand its contents. The claimant stated that he believed the DICS was a "work paper" that he was required to sign if he wanted to perform services for the employer. The claimant stated that Mr. Piranian instructed him to place his initials next to each of the nine criteria and to sign the document. The claimant did as he was told.

Mr. Piranian testified that the insurer provided the DICS to the employer, and the employer requires all carpentry workers to sign the DICS in order to perform services and receive pay from the employer. Mr. Piranian stated that he does not speak Spanish but understands "a little Spanish." Mr. Piranian stated that he asked the claimant in English whether he understood the DICS and the claimant replied, "yes" in English. Mr. Piranian stated that he couldn't state whether he went through each of the nine criteria with the claimant before he had the claimant initial them. Mr. Piranian stated that his partner speaks Spanish and could have explained the DICS to the claimant if the claimant did not understand it.

The ALJ credits the claimant's testimony that he did not understand the significance of the DICS or the nine criteria listed in the document. The ALJ is persuaded by the claimant's testimony that, although he speaks some English sufficient to perform his work and meet basic needs of living, he is not proficient enough in English to read and understand the technical legal language contained in the DICS. The ALJ also credits the claimant's testimony that correctly understood that if he wanted to perform work for the employer he had no choice but to sign the DICS and initial the nine criteria as indicated by Mr. Piranian. Mr. Piranian does not dispute that the employer required workers to sign the DICS if they desired to perform services for the employer, and admitted that this was a requirement of the insurer. In this regard the ALJ finds that in June 2007 the employer made no effort to provide the claimant with a written interpretation of the DICS in Spanish, and Mr. Piranian's partner was not present to interpret the document at the time it was signed. In these circumstances the ALJ finds that the claimant's signature on the DICS and the act of placing his initials next to the nine criteria is not persuasive evidence of a knowing and intelligent admission by the claimant that he was operating the business

of Michelle Construction as an independent contractor, or that he would not be considered an employee of the employer.

The claimant purchased a policy of general liability insurance for the benefit of the employer as required by the SA. However, the claimant did not have sufficient funds to purchase the insurance prior to commencing work for the employer. Instead, the employer loaned the claimant the money to purchase the insurance and began to make monthly deductions from the claimant's pay to recoup the cost of the insurance.

The claimant commenced working for the employer as a punch carpenter in June 2007.

The ALJ finds that, as a matter of fact, the employer did not require the claimant to work exclusively for the employer. The claimant was, at a theoretical level, free to work for other employers.

The employer, through its job-site supervisor, established specific hours of work that the claimant was expected to be on the job site performing carpentry services for the employer. The ALJ credits the claimant's testimony that he was expected to begin work at 7:00 a.m. and that the workday lasted until 4:30 p.m. Further, the claimant was expected to notify the supervisor if he needed to be absent during scheduled work hours. Mr. Gabriel Lopez, the work site supervisor on the date of the claimant's injury, corroborated the claimant's testimony concerning the designated hours of work. Mr. Lopez also admitted that if a carpenter came to the job and left whenever he pleased the carpenter would not be allowed to remain on the job. The claimant credibly explained that it would have been impossible for him to work for another employer considering the amount of work available through the employer, and because he was expected to work Monday through Saturday.

The employer established and enforced a "quality standard" with respect to the claimant's work. The claimant credibly testified that a supervisor working on behalf of the employer was present at the job site where the claimant worked. Furthermore, the claimant credibly testified that the supervisor inspected the work performed by the claimant and directed him to make corrections when the supervisor determined the work was defective or insufficient. The ALJ finds that witness Rodriguez corroborated the claimant's testimony with respect to the control and direction exercised by the employer. Mr. Rodriguez was performing carpentry services for the employer in August 2007, and he was working in relatively close proximity to the claimant when he was injured on the job. Mr. Rodriguez testified that the employer's supervisor would review his work and on some occasions tell him to make changes. Finally, Mr. Lopez, the employer's job site supervisor, admitted that he checked the quality of the claimant's work and would require changes if the work was not done correctly.

The employer paid the claimant at an hourly rate for the work performed. There was no written contractual arrangement between the claimant and employer establishing an overall contract or bid price for the work. The claimant did not submit a "bid" for the work to be performed. Rather, the claimant simply submitted "invoices" for his work. The amount of the invoices equaled the number of hours worked per week times the hourly

rate of pay. The invoices did not reflect negotiated prices for specific tasks or agreed upon sums for the completion of particular portions of the job. The claimant credibly testified that throughout his long career in the construction industry, including the eight years during which he performed services for the employer, he had been paid on an hourly basis.

There was no express contractual agreement between the claimant and the employer defining the "specifications" of the work to be performed or the period of time for completion of the work. The SA does not address these issues, other than to provide that the employer may charge back work if it "chooses to hire a different subcontractor to complete the unsatisfactory work." Therefore, the ALJ finds that under the arrangement between the claimant and employer the employer was free to terminate the claimant's work for any reason at any time. For instance, the ALJ credits the testimony of Mr. Lopez that the employer could have, and probably would have terminated the claimant's employment if it determined that his attendance was not satisfactory.

The employer did not provide more than minimal training to the claimant.

The claimant provided some of his own tools, and that the employer provided certain tools. The claimant credibly testified that he provided his own compressor, hoses, sawzall and other hand tools. However, the employer provided scaffolds and ladders. Mr. Rodriguez, who testified that the employer supplied certain tools including ladders, drills and wrenches corroborated the claimant's testimony regarding the ladders. Similarly, Mr. Rivas, who was working for the employer in August 2007, stated that the employer provided harnesses for working on roofs.

In 2007 the employer paid the claimant in the name of Michelle Construction rather than in the claimant's own name. However, under the facts of this case, the ALJ finds that payment of the claimant in the company name is not persuasive evidence that the claimant was operating an independent business or trade. As found, the claimant obtained the company name in 2001 because the employer "changed the rules" and began requiring all workers to submit a company name if they desired to continue performing services for the employer. The claimant worked for the employer in the year 2000, and did not have, nor was he required to have, a company name. Considering the totality of the evidence the ALJ infers that the claimant used the name "Michelle Construction" not because he was actually operating an independent business under that name, but because the employer required him to use the name to receive pay. The ALJ infers that the employer required the claimant to use the "company name" in order to comply with the insurer's requirements for establishing independent contractor status, not because the claimant was actually operating an independent trade or business.

There was, to some degree, a combining of "business operations" between the employer and the claimant. As found, the employer required the claimant to obtain a liability insurance policy for the employer's protection against claims resulting from the claimant's activities on the job. However, the claimant could not afford the insurance at the commencement of the employment in 2007. Consequently, the employer effectively loaned the claimant the money to purchase insurance and deducted the cost of the

insurance from the claimant's subsequent paychecks. The employer loaned this money not as an arms length business transaction between independent business entities, but as a method of attracting the claimant to perform services for the employer while placing the ultimate responsibility for mishaps on the claimant.

The claimant proved it is more probably true than not that he was an employee of the employer rather than an independent contractor when he was injured on August 10, 2007. Specifically, the claimant proved it is more probably true than not that he was subject to control and direction in the performance of services for the employer, and that he was not customarily engaged in an independent trade or business related to the services he performed for the employer. The claimant proved the existence of at least five factors tending to demonstrate that he was an employee rather than an independent contractor. The five factors are as follows: (1) The employer established and monitored the quality of the claimant's performance by having supervisors review the claimant's work and direct changes or corrections when necessary. The employer was actually overseeing the claimant's work. (2) The employer treated the claimant as an employee by paying an hourly wage. The claimant did not "bid" for specific jobs, and there was no overall contract price for the claimant's work. (3) The employer was free to terminate the claimant at any time without further liability to the claimant. Indeed, there were no "contractual specifications" that setting forth details of a mutually agreed upon standard of performance for the claimant's services. (4) The employer closely regulated the time of the claimant's performance of services. The employer set the hours of the claimant's performance and monitored his attendance through its appointed supervisors. (5) The employer combined business operations with the claimant by loaning the claimant money so that the claimant could purchase insurance to protect the employer's interests.

For the reasons stated above, especially the claimant's unfamiliarity with written English and the employer's insistence that the claimant sign the document in order to begin work for the employer, the ALJ finds the DICS does not constitute reliable and persuasive evidence that the claimant was, or agreed to become an independent contractor when working for the employer. Further, the factors and evidence tending to suggest the existence of an independent contractor relationship are not persuasive to the ALJ. Although the employer did not contractually require the claimant to work exclusively for it, the employer regulated the time of the claimant's performance and placed enough demands on the claimant's time that it would have been practically impossible for the claimant to work for another employer. The fact that the employer paid the claimant in the name of "Michelle Construction" is not persuasive evidence of independent contractor status. It was at the employer's behest that the claimant acquired the company name, and the claimant rarely used the name when he was working for other contracting entities. The ALJ infers that the claimant used the company name almost entirely because the employer required it and because the claimant needed the name in order to get paid by the employer. While the employer did not provide significant training to the claimant, the ALJ does not consider this fact to be of much significance since the claimant had been performing carpentry services most of his adult life and, inferentially, had little need for training. Further, both parties supplied some of the tools used by the claimant. In these circumstances the ALJ concludes that this factor "cuts both ways" and is given little significance.

The claimant credibly testified concerning the events of August 10, 2007. The claimant was performing carpentry services for the employer at one of the employer's job sites. While working on a garage the claimant fell off of a ladder and injured his right ankle. No representative from the employer referred the claimant to any facility or provider for medical treatment. Instead an electrician heard the claimant calling for help and called for paramedics.

The claimant was transported to Littleton Adventist Hospital. At the hospital the claimant was examined and treated by Dr. Gregory Taggart, M.D. Dr. Taggart performed a right ankle fusion before the claimant was released from the hospital.

On August 21, 2007, Dr. Taggart noted the claimant was restricted to non-weight bearing of the right lower extremity. On September 27, 2007, Dr. Taggart indicated the claimant could begin progressive weight bearing, but he was still in a cast. On October 23, 2007, the claimant was placed in a boot and allowed to bear weight as tolerated. In December 2007 Dr. Taggart recommended the removal of a screw that was causing ankle pain. However, on March 31, 2008, PAC Arro, on behalf of Dr. Taggart, noted the claimant had been scheduled for hardware removal in January 2008, but elected not to proceed because of "monetary constraints." Consequently, Dr. Taggart's office referred the claimant to the University of Colorado Hospital with the notation that the claimant needed "hardware removed as soon as possible."

Commencing in June 2008, the claimant began receiving treatment from Dr. Florin Costache, DPC of the University of Colorado Hospital podiatry clinic. On July 2, 2008, Dr. Costache noted the claimant had been unable to work since August 10, 2007. On September 9, 2009, Dr. Costache noted the claimant, "will most likely need future surgery for hardware removal and possible ankle joint re position if the rocker bottom shoes fail."

The claimant credibly testified that he has been unable to return to work since he was injured on August 10, 2007.

Based on the "invoices" that the claimant submitted, and the payment documents contained in the record, the ALJ finds the claimant's average weekly wage (AWW) at the time of injury was $673.50. This ALJ arrives at this AWW by averaging the claimant's earnings for the 10 weeks prior to the injury. The ALJ notes that the parties agreed on this AWW in their position statements.

The ALJ finds that evidence and inferences contrary to or inconsistent with these findings of fact are not credible and persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation.

Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

EMPLOYEE VERSUS INDEPENDENT CONTRACTOR STATUS

The claimant argues that the evidence establishes he was an employee of the employer on August 10, 2007. The respondents take the position that, although the claimant performed services for pay for the employer, the written DICS creates a presumption that the claimant was not an employee but was an independent contractor. The respondents further argue that the claimant failed to overcome presumption created by the DICS.

The claimant argues that the DICS constitutes a contract of adhesion and is not enforceable. Therefore, the claimant reasons that no presumption exists and the respondents bear the burden to prove he was an independent contractor rather than an employee. The ALJ need not reach the claimant’s theory that the DICS is an unenforceable “contract of adhesion” because, even if the DICS creates the presumption argued for by the respondents, the ALJ concludes the claimant overcame the presumption by a preponderance of the evidence.

Section 8-43-301(1)(a), C.R.S., conditions the right to recovery of workers’ compensation benefits on proof that the claimant is an employee of the employer. Section 8-40-202(2)(a), C.R.S., provides that an individual performing services for pay for another is deemed to be an employee:

> [U]nless such individual is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed.

Section 8-40-202(2)(b)(II), C.R.S., sets forth nine factors to balance in determining if the claimant is an employee or an independent contractor. *See Carpet Exchange of Denver, Inc. v. Industrial Claim Appeals Office*, 859 P.2d 278 (Colo. App. 1993). Section 8-40-202(2)(b)(III), C.R.S., provides that the existence of any one of those factors is not conclusive evidence that the individual is an employee. Consequently, the statute does not require satisfaction of all nine criteria in § 8-40-202(2)(b)(II) in order to prove by a preponderance of the evidence that the individual is not an employee. *Nelson v. Industrial Claim Appeals Office,* 981 P.2d 210 (Colo. App. 1998).

A document may satisfy the putative employer's burden to prove the claimant's status as an independent contractor. Both parties must sign such a document in order for it to be effective. Section 8-42-202(2)(b)(IV), C.R.S., further provides:

> Such document shall create a rebuttable presumption of an independent contractor relationship between the parties where such document contains a disclosure, in type which is larger than the other provisions in the document or in bold-faced or underlined type, that the independent contractor is not entitled to workers' compensation benefits and that the independent contractor is obligated to pay federal and state income tax on any moneys earned pursuant to the contract relationship. All signatures on any such document must be duly notarized.

It is not clear to the ALJ, and the ALJ is unaware of any case law that determines, whether the General Assembly intended that if the putative employer proves the existence of a document satisfying the criteria of § 8-42-202(2)(b)(IV) that the "rebuttable presumption" of independent contractor status shifts the *burden of proof* to the claimant to overcome the presumption that he was not an employee, or whether it merely shifts to the claimant the *burden of going forward* with evidence to negate or overcome the legal "presumption" of independent contractor status while leaving the ultimate burden of proof on the employer. *See Krueger v. Ary,* __P.3d__ (Colo. Sup. Ct. No. 08SC63, March 16, 2009) (a rebuttable presumption shifts only the burden of going forward with evidence sufficient to rebut the presumption, but does not shift the relevant burden of proof); *Cline v. City of Boulder,* 35 Colo. App. 349, 532 P.2d 770 (1975) (no universal rules to determine whether a rebuttable presumption places burden on party challenging presumption to produce evidence to counteract presumption or also places entire burden of persuasion on the challenger). Regardless of the correct legal interpretation of the rebuttable presumption created by § 8-42-202(2)(b)(IV), the Industrial Claim Appeals Office has held that if the employer proves the existence of a document sufficient to create the "rebuttable presumption," the claimant may yet prevail by proving as a matter of fact that he was not free from control and direction in the performance of service and was not customarily engaged in an independent trade or business. *Baker v. BV Properties, LLC,* W.C. No. 4-618-214 (ICAO August 26, 2005). Thus, even in the presence of a document satisfying § 8-42-202(2)(b)(IV), the claimant may establish that he was an employee if he proves that status under the preponderance of the evidence standard.

Considering this unsettled state of the law the ALJ assumes, without deciding, that the DICS signed by the claimant was sufficient to create a "rebuttable presumption" of independent contractor status as provided in § 8-42-202(2)(b)(IV). The ALJ further assumes, without deciding, that in these circumstances the statute places on the claimant the burden to overcome the presumption by proving it is more probably true than not that he was an employee rather than an independent contractor.

Having these factual and legal assumptions in mind, ALJ concludes the claimant proved it is more probably true than not that he was an employee of the employer because he was not free from control and direction in the performance of service for the employer, and was not engaged in an independent trade or business at the time of his injury. As specifically determined in Findings of Fact 24 and 25, the ALJ has considered the pertinent factors and finds the claimant proved he was not free from direction and control in the performance of services for the employer, and was not customarily engaged in an independent trade or business.

INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT

The claimant must prove by a preponderance of the evidence that his injury was proximately caused by an injury arising out of and in the course of his employment with employer. Section 8-41-301(1)(b) & (c), C.R.S.*; see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where the claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arising out of " element is narrower and requires claimant to show a causal connection between the employment and the injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Triad Painting Co. v. Blair*, *supra.*

As determined in Finding of Fact 26, the claimant proved it is more probably true than not that on August 10, 2007, he sustained an injury to his right lower extremity that arose out of and in the course of his employment as a carpenter with the employer. Specifically, the claimant was performing the duties of his employment when he fell from a ladder causing injury to his right lower extremity.

MEDICAL BENEFITS

The claimant seeks an award of medical benefits directing the respondents to pay for all treatment he received in connection with the injury of August 10, 2007. The ALJ notes the respondents' position statement does not contain any argument that the treatment received by the claimant is not authorized or is not reasonable and necessary. The ALJ concludes the claimant is entitled to an award of medical benefits.

Section 8-43-404(5)(a), C.R.S., gives the respondents the right in the first instance to select the authorized treating physician (ATP). Authorization refers to a physician's legal status to treat the industrial injury at the respondents' expense. *Bunch v. Industrial*

Claim Appeals Office, 148 P.3d 381 (Colo. App. 2006); *Popke v. Industrial Claim Appeals Office,* 944 P2d. 677 (Colo. App. 1997). Once an ATP has been designated the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

If upon notice of the injury the employer fails forthwith to designate an ATP, the right of selection passes to the claimant. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). The employer's obligation to appoint an ATP arises when it has some knowledge of the accompanying facts connecting an injury to the employment such that a reasonably conscientious manager would recognize the case might result in a claim for compensation. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006).

Authorized providers also include providers to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office,* 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). Whether an ATP has made a referral in the normal progression of authorized treatment is a question of fact for the ALJ. *Suetrack USA v. Industrial Claim Appeals Office,* 902 P.2d 854 (Colo. App. 1995).

A claimant may also obtain "authorized treatment" without giving notice and obtaining a referral from the employer if the treatment is necessitated by a bona fide emergency. Once the emergency is over the employer retains the right to designate the first "non-emergency" physician. *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990).

Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

The ALJ concludes that claimant proved it is more probably true than not that the treatment he received on and after August 10, 2007, was "authorized." The claimant credibly testified that the injury occurred on the employer's job site and that no employer representative designated a physician or medical provider to render treatment. Instead, the "paramedics were called" and arrived at the job site. The ALJ infers from other evidence, including the testimony of the claimant and his supervisor Mr. Lopez, that it was customary for the employer to have a supervisor present on the job site, and further that one was present on the date of the injury. The ALJ notes there is no credible or persuasive evidence to the contrary. In these circumstances the ALJ concludes that the employer knew of the claimant's injury but did not refer the claimant to an authorized physician or provider. In these circumstances the ALJ concludes that the right of selection passed to the claimant and he selected Dr. Taggart as the ATP.

Alternatively, even if the right of selection had not passed, the ALJ finds that the treatment provided at the Littleton Adventist Hospital and by Dr. Taggart during the claimant's hospital stay in August 2007 was the result of a bona fide emergency and was authorized.

The ALJ also concludes the claimant proved that the treatment rendered by Dr. Costache, DPC of the University of Colorado Hospital podiatry clinic was authorized. The ALJ concludes that Dr. Taggart determined that he would no longer provide treatment to the claimant and referred the claimant to Dr. Costache for follow-up treatment. The ALJ concludes this referral was made in the ordinary course of treatment because Dr. Taggart declined to provide further treatment, although he considered further treatment to be necessary.

The ALJ concludes from the medical records submitted and the testimony of the claimant that the treatment provided for the injury of August 10, 2007 has been reasonable and necessary to cure and relieve the effects of the injury. The records establish that the claimant sustained as serious injury requiring surgery, and that the need for treatment of the effects of the injury has not entirely abated.

TEMPORARY TOTAL DISABLITY BENEFITS

The claimant seeks an award of temporary total disability (TTD) benefits commencing August 11, 2007, and continuing until terminated by law or order. Again, the respondents' position statement does not specifically address this issue. The ALJ concludes the claimant is entitled to an award of TTD benefits.

To prove entitlement to TTD benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires the claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998). TTD benefits ordinarily continue until one of the occurrences listed in § 8-42-105(3), C.R.S.; *City of Colorado Springs v. Industrial Claim Appeals Office, supra*.

The existence of disability presents a question of fact for the ALJ. There is no requirement that the claimant produce evidence of medical restrictions imposed by an ATP, or by any other physician. Rather, lay evidence alone may be sufficient to establish disability. *Lymburn v. Symbios Logic,* 952 P.2d 831 (Colo. App. 1997).

The ALJ concludes the claimant proved it is more probably true than not that he is entitled to an award of TTD benefits commencing August 11, 2007, and continuing. As determined in Finding of Fact 30, the claimant credibly testified that he has been unable to return to work since he fell and injured his ankle on August 10, 2007. The claimant's testimony is corroborated by the medical evidence showing that the injury required a fusion surgery, that after the surgery the claimant has been under varying degrees of non-weight bearing and limited weight bearing restrictions, and Dr. Costache's July 2, 2008 written statement that the claimant has been unable to work since August 10, 2007. No credible or persuasive evidence establishes that the claimant's right to receive TTD benefits has been terminated in accordance with law or order.

AVERAGE WEEKLY WAGE

The ALJ concludes the claimant's AWW is $673.50. In determining the AWW the ALJ has exercised his discretion under Section 8-42-102(3), C.R.S., to use a method that will fairly calculate the AWW under the circumstances of the case. The ALJ has averaged the claimant's earnings over the 10 weeks prior to the injury. The ALJ notes that the claimant's earnings were somewhat irregular from week to week and the claimant had not been on the job very long at the time of the injury. Therefore, the ALJ has concluded, in agreement with the parties, that this averaging method is the fairest way to calculate the AWW.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2.Issues not resolved by this order are reserved for future determination.

3. The insurer shall pay the claimant TTD benefits commencing August 11, 2007, and continuing until terminated by law or order. The TTD benefits shall be paid in accordance with the statutory formula, and shall be clculated based on the AWW of $673.50.

4. The respondent shall pay the claimant's reasonable and necessary medical expenses resulting from the industrial injury including the treatment and services provided by Littleton Adventist Hospital, Dr. Taggart, and Dr. Costache. Payment shall be made in accordance with the fee schedule.

DATED: July 15, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-601-867

ISSUES

The following issues were raised for consideration at hearing:

A. Should Respondents be permitted to offset 50% of the mandatory federal reduction taken against Claimant's Social Security disability benefits paid for attorneys' fees in seeking such award?

B. Should Respondents be permitted to take an overpayment based upon the cost-of-living adjusted amount of benefits awarded, or are they limited to the originally awarded benefit calculation?

FINDINGS OF FACT

1. Claimant was working within the course and scope of her employment on September 30, 2003, when she sustained injuries to her lumbar spine. Respondents have admitted liability for a 46% permanent whole person impairment.

2. Claimant was determined to be eligible for Social Security Disability Insurance (SSDI) benefits, a federal disability benefit, on January 21, 2008. Claimant was awarded SSDI benefits beginning in April 2004. The initial SSDI monthly benefit was $677.00 per month.

3. In December of each year from 2004 to 2007, Claimant received cost-of-living adjustments. Claimant's eligibility for SSDI was not determined until January 2008. As of that date, Claimant's SSDI monthly benefit amount was $764.60 per month.

4. The past due benefits awarded was calculated to be $32,160.00 for April 2004 through December 2007. That total past-due benefit award included benefits at the yearly increased value according to the cost-of-living adjustments.

5. Claimant's SSDI award was reduced for attorney fees in the amount of $5,221.00. An expense of $509.50 for an expert vocational evaluation in connection with the SSDI claim was charged to Claimant by experts in order to obtain the favorable award.

6. Respondents filed a Final Admission of Liability on January 22, 2009, claiming an offset for SSDI benefits between April 1, 2004, and June 23, 2008, in the amount of $17,346.68, plus an additional $86.58 per week from August 8, 2008, through December 8, 2008. Respondents thereafter claimed an offset of $78.12 per week as an offset against ongoing permanent total disability benefits.

7. The parties stipulated to the following facts that have been adopted by the ALJ:

a. Respondents insisted Claimant apply for Social Security benefits;

b. Respondents never offered any assistance by way of provision of representation or advance of costs, nor provided any other assistance of any kind to Claimant in applying for or seeking an award of SSDI benefits;

c. The Employers' First Report states the date of hire was August 5, 2003; and

d. The date of injury was September 30, 2003.

CONCLUSIONS OF LAW

A. Should Respondents be permitted to offset 50% of the mandatory federal reduction taken against Claimant's Social Security Disability benefits paid for attorneys' fees in seeking such award?

Under Section 8-42-103(1)(c), C.R.S., Respondents may reduce the aggregate benefits payable for permanent total disability benefits by an amount equal to one-half of SSDI benefits granted to Claimant.

The Colorado Court of Appeals in *St. Vincent's Hospital v. Alires*, 778, P.2d 277 (Colo. App. 1989), held that an employer and insurer were not entitled to offset workers' compensation benefits from that portion of the lump sum Social Security Disability benefits awarded to Claimant which was withheld from payment to her as attorney's fees. In *Jones v. Industrial Claim Appeals Office*, 892 P.2d 425 (Colo. App. 1994), the Court confirmed how the offset should be calculated. The Court found that, because attorney's fees are deducted before calculation of the offset, the Claimant and the insurer each bear one-half of the fees.

The costs of $509.50 must also be deducted pursuant to *County Workers' Compensation Pool v. Davis*, 817 P.2d 521 (Colo. 1991).

Respondents shall be permitted to offset 50% of the mandatory federal reduction taken against Claimant's Social Security Disability benefits paid for attorneys' fees and costs in seeking such award.

B. Should Respondents be permitted to take an overpayment based upon the cost-of-living adjusted amount of benefits awarded or are they limited to the originally awarded benefit calculation?

When determining the amount of offset for SSDI that respondents may be entitled, events occurring after the injury which increase the amount of SSDI benefits may not be seen to lead to an increased offset to respondents. *Englebrecht v. Hartford Accident & Indemnity Co.,* 680 P.2d 231 (Colo. 1984). Therefore, cost-of-living increases to SSDI benefits do not increase the offset available to respondents. *Id. See Martinez v. Industrial Commission*, 746 P.2d 552 (Colo. 1987); *Dietiker v. Colorado Kenworth* W.C. 2-933-575 (ICAO, Jan. 5, 1993). "*Engelbrecht, supra,* stands for the proposition that the respondents are entitled to an offset based on the initial award of SSDI benefits to the claimant and his dependents, and later cost-of-living adjustments to the initial award do not affect the offset." *Id.*

Respondents may not take an offset based on the cost-of-living adjusted amount of benefits awarded. Respondents are limited to the originally awarded benefit calculation.

The SSDI offset must be based upon the original award of $677.00 per month. This results in a weekly offset of $77.90 (i.e. $677.00 x 12 months / 52.14 weeks per year x 50%) per week. The overpayment must be based on the overpayment from April 1, 2004, the date of entitlement to SSDI benefits, until December 8, 2008, when Respondents began taking the offset. During this time there was an overpayment of $19,052.45. Both the attorney's fees and the costs incurred by Claimant in the Social Security claim need to be taken into consideration. These total $5,730.50. Therefore, one-half of this must be deducted from the overpayment, resulting in an overpayment of $16,187.20.

Respondents admitted, however, already reducing Claimant/s permanent total disability benefits by $86.58 per week from August 8, 2008 through December 8, 2008 (17.43 weeks) thereby already reducing the resulting overpayment by reduced by Respondents however by $1,508.97 ($86.58 x 17.429 weeks). Therefore the final resulting overpayment is $14,678.23.

Although not listed as an issue in either party's proposed order, both parties have addressed the issue of the Medicare premium deducted from the SSDI benefits. There is no legal basis in either the statute or the case law for deducting the Medicare premium from the offset allowed Respondents. This is the premium that Claimant must pay for her insurance and should not be deducted from the overpayment made by Respondents.

It is therefore concluded that Respondents have overpaid benefits in the amount of $14,678.23. [i]

The amount of the overpayment has substantially changed since the previous order. The previous Petition to Review is stricken as moot. If any party is dissatisfied with this order, the party must file a new Petition to Review.

ORDER

Respondents may offset benefits payable to Claimant by $14,678.23.

All matters not determined herein are reserved for future determination.

DATED: *July 15, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

Mark

DETAIL OF CALCULATIONS:

$677.00	SSDI per month
$8124.00	SSDI per year
$22.258	SSDI per day
$155.803	SSDI per week
$77.901	offset per week
4/1/2004	SSDI began
12/8/2008	overpayment ended
1712	days
244.571	weeks
$19052.45	Overpayment
$5730.50	Atty fees & costs
$2865.25	one-half
$16187.20	Net Overpayment
$86.58	Insurer took overpayment
08/08/08	began
12/08/08	ended
17.429	weeks
$1508.97	Overpayment already taken
$14678.23	Final Overpayment

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-805

ISSUES

- Compensability: Whether Claimant was in the course and scope of his employment when he sustained an injury on December 1, 2008.

- Temporary Total Disability (TTD): Whether Claimant is entitled to temporary total disability from December 1, 2008 and ongoing.

- Medical Benefits: Whether Claimant is entitled to medical benefits to treat the injury sustained on December 1, 2008.

FINDINGS OF FACT

1. Claimant began working for Employer in February 2008 as a maintenance technician. Claimant's job duties involved repairing and maintaining kitchen equipment in commercial kitchens. The Denver office located on 58th Avenue and I-25 covers Northern Colorado, Southern Wyoming, Western Kansas and Eastern Utah. Claimant was required to travel anywhere within the region to the client's kitchens.

2. Employer issued a full sized van to Claimant for travel to and from each worksite. Claimant kept the van at his condominium on a side street near the condominium complex because his garage was not large enough to house the van. Claimant never kept the work van at Employer's Denver office.

3. At the end of each workday, the dispatcher usually gave Claimant his first appointment for the following morning. Claimant's daily routine involved departing from his home in the morning at approximately 7 a.m. and driving the Employer's van directly to his first appointment. Throughout the remainder of the workday, the dispatcher would send Claimant to other appointments at different locations within the region. Claimant drove the van to all of the appointments and would then drive the van directly home at the end of the workday. Employer approved this routine and allowed Claimant and other employees to keep the work vans at their homes.

4. According to Employer's policy, an employee's work shift begins 30 minutes after he departs from his home unless he arrives at his first destination within 30 minutes of departure. Claimant received hourly compensation for the remainder of the work day whether driving or performing maintenance work.

5. On December 1, 2008, Claimant left his home at approximately 7 a.m. to walk to the work van. It had snowed during the night before leaving snow and ice on the ground. Once Claimant arrived at the van, he got inside, started it then turned on the heater and defroster. Claimant grabbed the ice scraper from behind the seat then exited the van. Once outside, he began cleaning the snow and ice from the van starting with the windshield. While walking toward the back of the van, he slipped and hit the left side of the back of his head on the van's bumper. He also struck his left elbow

6. Claimant woke up feeling confused and dazed. He finished cleaning the van and drove away at approximately 8 a.m. He called his dispatcher to advise her that he was going to Concentra after his first appointment. The dispatcher asked him to stop at another worksite before going to Concentra. The Claimant stopped to pick up parts before going to the second appointment. When he returned to his van, he starting getting a headache and feeling anxious. He contacted the dispatcher and

advised her that he was skipping the second appointment and going directly to Concentra.

7. Claimant arrived at Concentra at approximately 8:45 a.m. with complaints of headache, photophobia and left elbow pain. Dr. Christian Updike evaluated Claimant and assessed a concussion with loss of consciousness/amnesia. Dr. Updike declared Claimant unfit to drive and instructed him not to work for the remainder of the day. He also referred Claimant for a head CT scan which Claimant underwent at St. Anthony's. The scan results were normal.

8. Claimant returned to Dr. Updike on December 18, 2008. Dr. Updike noted although the Respondents had denied Claimant's workers' compensation claim, he wanted to reevaluate Claimant. Dr. Updike's report notes that Claimant was stuttering and had problems with word finding, that his comprehension appears excellent, but that he was unable to stand with eyes closed for longer than two second without severe swaying. He further noted that Claimant was unable to test finger-nose-finger due to dizziness with head tilting. Dr. Updike again declared that Claimant was unfit for duty.

9. On January 7, 2009, Dr. Updike released Claimant from care and released him to full duty with the recommendation that Claimant not drive, work at heights or in safety sensitive areas. Dr. Updike declared Claimant at maximum medical improvement. Claimant has not returned to work due to these restrictions.

10. Claimant has continued to seek treatment with his personal physician, Dr. Kenney, since Respondents denied the claim. Such treatment includes occupational, cognitive and speech therapy in addition to evaluations with neuropsychologists, Dr. Schraa and Dr. Ravishar.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge enters the following conclusions of law:

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102 (1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

Compensability

4. A claimant must prove by a preponderance of the evidence that his injury arose out of the course and scope of his employment with employer. *Section 8-41-301(1)(b), C.R.S.; see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arise out of " requirement is narrower and requires claimant to show a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See id.* Nevertheless, the employee's activity need not constitute a strict duty of employment or confer a specific benefit on the employer if it is reasonably incidental to the conditions under which the employee typically performs the job. *Swanson,* W.C. No. 4-589-545.

5. In general, claimants injured while going to or coming from work fail to qualify for recovery because such travel is not considered performance of services arising out of and in the course of employment. *Madden v. Mountain West Fabricators,* 977 P.2d 861 (Colo. 1999). A number of exceptions have arisen when special circumstances demonstrate a sufficient causal relationship between the injury and the employment. This involves a fact-specific analysis considering a number of factors, including, but not limited to, the following: 1) whether the travel occurred during working hours, 2) whether the travel was on or off the employer's premises, 3) whether the travel was contemplated by the employment contract, and 4) whether the employment created a zone of special danger. If only one variable is present, "recovery depends upon whether the evidence supporting that variable demonstrates a causal connection between the employment and the injury such that the travel to and form work arises out of and in the course of employment." *Id.* at 865. Here, travel was contemplated by the employment contract, but Respondents contend that Claimant had not yet begun traveling when the accident occurred.

6. When the employer provides transportation, pays the cost of transportation or provides compensation for travel, injuries sustained during the travel have a sufficient causal relationship to the employment to be compensable. *Staff Administrators, Inc. v. Reynolds,* 977 P.2d 866 (Colo. App. 1999); *Industrial Commission v. Lavach,* 165 Colo. 433, 439 P.2d 359 (1968); *Monolith Portland Cement v. Burak,* 772 P.2d 688 (Colo. App. 1989). As found, Employer provided a van to Claimant so that Claimant could perform his daily job duties. Claimant received compensation while traveling to his first assignment beginning 30 minutes after he departed, and he continued to receive compensation while traveling between jobsites throughout the remainder of his workday. No explanation was provided for why the Employer does not compensate an employee until 30 minutes after the employee departs from his home.

7. Based on the foregoing, Claimant has established that he was in the course and scope of his employment when he slipped and fell on December 1, 2008, while cleaning snow from the Employer's van. Claimant has established that the accident had a sufficient causal relationship to his employment. Travel is a substantial part of the service performed by Claimant for Employer. Claimant was expected to drive the Employer-owned van from his home to his first appointment on a daily basis and then drive to all subsequent appointments in the same van then drive the van to his home. Respondents argue that the contemplated travel had not yet begun when Claimant fell and that the action of removing snow from the van was merely in preparation for travel. Respondents' argument is unpersuasive. Preparatory activities or activities reasonably incidental to the conditions under which an employee performs his job may be sufficiently related to the employee's job duties. *See Swanson,* W.C. No. 4-589-545. Here, Employer could not have reasonably expected Claimant to drive without first clearing the snow from the Employer's van. Cleaning the van was preparatory or incidental to Claimant's ability to perform his essential job duty of traveling to the various jobsites. Moreover, cleaning the snow from the van is necessarily a part of traveling in the van.

Medical Benefits

8. Section 8-42-101(1)(a), supra, provides:

> Every employer … shall furnish … such medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury … and thereafter during the disability to cure and relieve the employee from the effects of the injury.

Respondents thus are liable for authorized medical treatment reasonably necessary to cure and relieve the employee from the effects of the injury. Section 8-42-101, *supra*; *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). Claimant has established that he sustained a compensable injury to his head and elbow when he slipped and fell on December 1, 2008. Respondents shall provide reasonable and necessary treatment to cure and relieve the effects of the injury, which shall include payment for authorized treatment already received.

Temporary Total Disability

9. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury or disease caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform her regular employment. *Ortiz v. Murphy*, 964 P.2d 595 (Colo. App. 1998).

10. Claimant has been unable to perform his normal job duties as a maintenance technician since the accident on December 1, 2008. While it is true that Dr. Updike noted that he released Claimant to full duty, he also prohibited Claimant from driving, working at heights or in safety sensitive areas. Because Claimant's job requires driving, he cannot effectively and properly perform his normal job. As such, Claimant is entitled to TTD commencing on December 1, 2008 until terminated by statute.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable injury on December 1, 2008.

2. Respondents are responsible for providing Claimant medical benefits to cure and relieve the effects of the injury.

3. Claimant is entitled to TTD commencing on December 1, 2008 until terminated pursuant to statute subject to applicable offsets and credits.

4. The Insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

DATED: July 15, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-759-516

ISSUES

The issues presented for determination were the computation of the Claimant's AWW and Claimant's claim for TPD benefits from May 15, 2008 and continuing.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as an Assistant Nitrogen Operator. On February 26, 2008 Claimant sustained an admitted injury to his low back when he was coming down a ladder, slipped and fell.

2. At the time of Claimant's injury, he was paid $13.20 per hour for a guaranteed 40-hour work week. Claimant began receiving this wage on June 25, 2007 when his pay rate was increased after he completed training. Prior to this Claimant was paid $12.00 per hour.

3. In addition to a guaranteed 40-hour work week Claimant also worked overtime that was paid at 1 ½ times the standard hourly rate.

4. In addition to his regular wage and overtime pay, Claimant received contribution from Employer to a 401k plan in the amount of 4% of his gross pay.

5. After the injury of February 26, 2008 Claimant continued to perform his regular work. Effective May 15, 2008 Claimant was placed on restrictions by the authorized physician, Dr. Cody Heimer, M.D. of no lifting, repetitive lifting, carrying or pushing/pulling in excess of 20 pounds. Claimant was also to minimize twisting and bending. Claimant was unable to perform his regular job within these restrictions.

6. After being placed on restrictions Claimant continued to work modified duty for Employer consisting primarily of driving and fueling vehicles. Claimant continued to work for Employer until August 12, 2008 when he was terminated.

7. For the period from June 25, 2007 through March 2, 2008, a period of 36 weeks, Claimant earned a total of $33,055.80. At the rate of $13.20 per hour for a 40-hour week, $19,008.00 of this was regular pay. Claimant earned $14,047.80 in overtime or premium pay during this period ($33,055.80 - $19008.00) for an average of overtime pay of $390.22 per week ($14,047.80/36 = $390.22).

8. Effective March 31, 2008 Claimant's hourly wage rate increased to $13.53 per hour. For a guaranteed 40-hour week Claimant would receive $541.20 ($13.53 x 40). Based upon Claimant's prior earnings the average weekly contribution to Claimant's 401k account by Employer was $37.65. Combining Claimant's regular earnings of $541.20 with an average of $399.98 per week in overtime and $37.65 per week in contribution to Claimant's 401k, Claimant's average weekly wage effective March 31, 2008 was $978.83.

9. For the period from May 12 through August 11, 2008 after Claimant was placed on restrictions and was no longer able to perform his regular work Claimant earned a total of $7820.55 for this 13 1/7-week period. Claimant's average earnings during this period were $595.04 ($7820.55/13.143 = $595.04). At the rate of 4% of gross pay Employer contributed an average weekly amount of $23.81 to Claimant's 401k during this period. Claimant's average weekly earnings from May 12 through August 11, 2008 were $618.85 ($595.04 + $23.81).

10. Claimant was provided health and dental insurance that was paid by Employer. Effective August 31, 2008 Claimant's health and dental insurance through Employer was terminated due to Claimant's termination from employment. The weekly cost of continuing the Employer's health and dental insurance for Claimant was $65.15. With the addition of the replacement cost of the Employer's health and dental insurance Claimant's AWW increased to $1043.98 effective August 31, 2008 ($978.83 + $65.15 = $1043.98).

11. Claimant's loss of wages beginning May 15, 2008 were due to Claimant being placed on restrictions for his work injury that prevented Claimant from performing his regular work. Claimant became disabled as of May 15, 2008.

12. For the period from May 15 through August 31, 2008 Claimant is entitled to TPD benefits at the rate of $239.99 per week based upon two-thirds of the difference between Claimant's AWW prior to August 31, 2008 and the Claimant's average earnings during this period ($978.83 - $618. 85 = $359.98 x 2/3 = $239.99).

13. For the period from September 1, 2008 and continuing Claimant is entitled to TPD benefits of $283.42 per week based upon two-thirds of the difference between Claimant's AWW effective August 31, 2008 and the weekly average of Claimant's earnings while on modified duty prior to his termination from employment with Employer ($1043.98 - $618.85 = $425.13 x 2/3 = $283.42).

CONCLUSIONS OF LAW

14. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

15. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

16. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

17. The purpose of calculating a Claimant's AWW is to arrive at a fair approximation of the Claimant's wage loss and diminished earning capacity from a work-related injury. *Lawrence v. HVH Transportation, Inc.,* W.C. No. 4-398-905 (October 18, 1999). While calculation of the AWW is generally tied to the time of injury, the discretionary exception found in Section 8-42-102 (3), C.R.S. affords the ALJ the discretion to determine a Claimant's AWW, including the cost for continuation of health

insurance, based not only on the Claimant's wage at the time of the injury, but also on other relevant factors when the case's unique circumstances require. *Avalanche Indus. V. Gladys Clark and Indus. Claim Appeals Office,* __ P.3d ___, 07SC255 (Colo. 2008). The ALJ can base an AWW on a salary that Claimant was actually earning when forced to stop working. *Avalanche Indus.,* supra. The Claimant's AWW may be based upon the Claimant's earnings at the time of an onset of disability. *Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993).

18. The ALJ concludes that using the Claimant's hourly wage in effect at the time of the injury would not fairly approximate Claimant's wage loss once he became disabled effective May 15, 2008. To do so would understate the wage loss suffered by Claimant after this time due to his inability to continue his regular work from the effects of the admitted injury. Claimant's wage loss beginning May 15, 2008 is best measured by using Claimant's hourly rate in effect at that time combined with an average of overtime earnings Claimant would have received and the Employer's average contribution to the Claimant's 401k account. Neither party has argued that this latter amount should not be included into the computation of the AWW but have merely proposed differing values.

19. Under Section 8-42-106, C.R.S., "in case of temporary partial disability, the employee shall receive sixty-six and two-thirds percent of the difference between the employee's average weekly wage at the time of the injury and said employee's average weekly wage during the continuance of the temporary partial disability, " As found, Claimant's AWW during his period of TPD was $625.64. Claimant is therefore entitled to TPD benefits at two-thirds of the difference between this AWW and Claimant's AWW for the injury, as adjusted for Claimant's cost of continuing the Employer's health insurance coverage once it was lost.

ORDER

It is therefore ordered that:

Claimant's AWW beginning May 15, 2008 is $978.83. Beginning August 31, 2008 Claimant's AWW is increased to $1043.98.

Insurer shall pay Claimant TPD benefits at the rate of $239.99 per week for the period from May 15 through August 31, 2008 inclusive.

Insurer shall pay Claimant TPD benefits at the rate of $283.42 per week beginning September 1, 2008 and continuing until terminated in accordance with statue, rule or order.

Insurer shall be entitled to take credit for all amounts of TPD benefits previously admitted and paid during these periods.

The Insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: July 15, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-597-096

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he is entitled to reopen his worker's compensation claim based on a change in condition pursuant to §8-43-303(1), C.R.S.

2. If Claimant is permitted to reopen his claim, whether he has demonstrated by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period February 26, 2008 until terminated by statute.

FINDINGS OF FACT

1. Claimant worked for Employer as a cement truck driver. On October 9, 2003 he sustained a left shoulder injury during the course and scope of his employment with Employer.

2. Claimant subsequently underwent diagnostic testing that included an MRI of the left brachial plexus. The MRI did not reveal any evidence of a cervical nerve root sleeve avulsion or left brachial plexus injury.

3. During the course of Claimant's treatment for his left shoulder condition he also underwent electrodiagnostic studies. The electrodiagnostic studies revealed multiple abnormalities that included diffuse polyneuropathy, severe carpal tunnel syndrome and ulnar neuropathy at the left elbow. Claimant's conditions constituted nerve injuries unrelated to his compensable left shoulder condition.

4. Claimant did not injure his neck or right shoulder in his industrial accident. However, on December 4, 2003 Claimant advised Dr. Mann that he had problems with his right shoulder. Dr. Mann remarked that Claimant would have to evaluate his right shoulder symptoms through his private insurance.

5. On November 23, 2003 Claimant underwent a left shoulder arthroscopy with Thomas Mann, M.D. Claimant reached Maximum Medical Improvement (MMI) for his left shoulder condition on July 12, 2004.

6. On July 22, 2004 Respondents filed a Final Admission of Liability (FAL). The FAL acknowledged Claimant's 25% left upper extremity impairment rating.

7. On January 10, 2005 Claimant returned to Dr. Mann specifically for problems associated with his right shoulder. An MRI showed right shoulder degenerative changes with cuff tendinopathy. On February 4, 2005 Claimant underwent right shoulder surgery. The surgery was handled through Claimant's private health insurance.

8. Based on a worsening of condition, Claimant's claim was reopened. On September 5, 2006 Claimant underwent a total left shoulder arthroplasty with David J. Schneider, M.D. Claimant's shoulder surgery was successful and he again reached MMI on February 27, 2007. Authorized Treating Physician (ATP) Andrew Plotkin, M.D. assigned Claimant a 41% left upper extremity impairment rating for his shoulder condition.

9. An MRI of Claimant's cervical spine revealed a spinal cord syrinx formation. On January 3, 2007 Dr. Schneider directed Claimant to pursue the evaluation of his syrinx condition through his personal health insurance. However, Claimant has not undergone any additional syrinx evaluations through personal physicians.

10. On March 21, 2007 Respondents filed a FAL recognizing Dr. Plotkin's MMI date and assignment of a 41% upper extremity rating for Claimant's left shoulder injury. Claimant did not challenge his February 27, 2007 MMI date or impairment rating by requesting a Division Independent Medical Examination (DIME).

11. On April 26, 2007 Claimant underwent a left carpal tunnel release and left upper extremity ulnar nerve decompression for his unrelated nerve injuries.

12. Claimant testified that after he reached MMI his condition began to deteriorate. He explained that he suffered from pain in his shoulders, neck and lower back that prevented him from performing his extensive household chores. Claimant remarked that, because of neurological symptoms, he could not use his left hand unless he looked directly at the object he intended to manipulate. He also resigned his position as a cement truck driver because he could no longer safely perform his required job tasks.

13. On September 18, 2008 Claimant filed a Petition to Reopen based on a change in medical condition.

14. On December 29, 2008 Claimant visited ATP James Fox, M.D. for an evaluation. Dr. Fox noted that Claimant complained of numerous problems including shoulder weakness, limited mobility, chronic shooting pain down his wrist and arm numbness, that interfered with his normal activities of daily living. After reviewing the medical records, Dr. Fox determined that Claimant remained at MMI but that his condition warranted medical maintenance treatment. He remarked that he would not reopen the case "unless further treatment is indicated." Dr. Fox referred Claimant to neurosurgeon James S. Ogsbury, III, M.D. for an evaluation.

15. On February 26, 2009 Claimant visited Dr. Ogsbury for an evaluation. Based on a consideration of the mechanism of Claimant's left shoulder injury and a review of the medical records, Dr. Ogsbury remarked that Claimant could have suffered a "significant brachial plexus stretch injury" on October 9, 2003. He thus recommended a brachial plexus MRI.

16. On March 5, 2009 Claimant underwent an independent medical examination with John S. Hughes, M.D. After reviewing Claimant's medical records and conducting a physical examination, Dr. Hughes concluded that Claimant "sustained a relatively high energy injury on October 9, 2003" and thus probably suffered a "significant injury-related brachial plexopathy." He also noted that Claimant had experienced a "primary injury to the cervical spine."

17. On April 3, 2009 Dr. Ogsbury issued a letter regarding the results of Claimant's brachial plexus MRI. Dr. Ogsbury stated that no abnormalities existed in Claimant's brachial plexus but that he had abnormalities in the right shoulder joint and a syrinx formation. He thus remarked that, although it was possible that Claimant suffered a brachial plexus injury, the absence of left shoulder abnormalities suggested that no additional treatment would be necessary or helpful. Dr. Ogsbury returned Claimant to Dr. Fox for the completion of care.

18. On April 15, 2009 Claimant returned to Dr. Fox for a maintenance visit. Dr. Fox remarked that Claimant had undergone extensive evaluation by numerous specialists and that his left shoulder arthroplasty was in place and functioning properly. He thus concluded that Claimant remained at MMI. Nevertheless, Dr. Fox referred Claimant for a medical maintenance visit to a pain management specialist.

19. On April 29, 2009 Claimant visited Douglas Hemler, M.D. for maintenance treatment. Dr. Hemler agreed with Dr. Fox that Claimant's left shoulder was stable and that he did not require any additional treatment. He remarked that Claimant's "persistent myofascial pain and left upper extremity numbness are most likely explainable based on the presence of a syrinx." Dr. Hemler thus concluded that Claimant remained at MMI.

20. On April 29, 2009 Dr. Hughes issued a letter in which he stated that Claimant suffered from "[p]rogressive neuropathy of unclear etiology, but with clinical features that suggest a left C6 radiculopathy." He thus concluded that Claimant had sustained a worsening of condition since reaching MMI.

21. On May 20, 2009 the parties conducted the evidentiary deposition of Dr. Fox. Dr. Fox reiterated that Claimant remained at MMI because additional intervention would not be beneficial. Nevertheless, he referred Claimant to a pain management specialist for medical maintenance treatment. Dr. Fox also noted that there was no strong evidence to support Dr. Hughes' comment that Claimant possibly had a C6 radiculopathy. Moreover, Dr. Fox commented that in Claimant's six years of treatment from 10 doctors, no other doctor determined that Claimant sustained neck trauma that caused a C6 radiculopathy. Furthermore, no other doctor had recommended additional diagnostic testing of Claimant's left shoulder.

22. Claimant has failed to demonstrate that it is more probably true than not that he suffered a worsening of his left shoulder condition that warrants a reopening of his claim. ATP Dr. Fox credibly explained that Claimant's left shoulder arthroplasty is in place and continues to function properly. He thus concluded that Claimant remained at MMI. Dr. Ogsbury noted that an MRI revealed no abnormalities in Claimant's brachial plexus but only abnormalities in the right shoulder joint and a syrinx formation. He thus remarked that, although it was possible that Claimant suffered a brachial plexus injury on October 9, 2003, the absence of left shoulder abnormalities suggested that no additional treatment would be necessary or helpful. Finally, Dr. Hemler agreed with Dr. Fox that Claimant's left shoulder was stable and that Claimant remained at MMI. He remarked that Claimant's persistent myofascial pain and left upper extremity numbness were attributable to the presence of the syrinx formation. In contrast, Dr. Hughes commented that Claimant suffered a worsening of condition as a result of progressive neuropathy. He attributed Claimant's symptoms to a possible C6 radiculopathy. However, Dr. Fox persuasively noted that in the six years of Claimant's treatment from 10 doctors, no other doctor had determined that Claimant sustained neck trauma on October 9, 2003 that caused a C6 radiculopathy. Claimant has therefore failed to demonstrate that he experienced a change in his physical condition that can be causally connected to his original compensable injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-43-303(1), C.R.S. provides that a workers' compensation award may be reopened based on a change in condition. A "change in condition" refers to a "change in the condition of the original compensable injury or to a change in claimant's physical or mental condition which can be causally connected to the original compensable injury." *Cordova v. Industrial Claims Comm'n.,* 55 P.3d 186, 189 (2002); *In re Caraveo,* W.C. No. 4-358-465 (ICAP, Oct. 25, 2006). Reopening is appropriate when the claimant's degree of permanent disability has changed since MMI or where the claimant is entitled to additional medical or temporary disability benefits that are causally connected to the compensable injury. *See In Re Duarte,* W.C. No. 4-521-453 (ICAP, June 8, 2007). The determination of whether a claimant has sustained his burden of proof to reopen a claim is one of fact for the ALJ. *In re Nguyen,* W.C. No. 4-543-945 (ICAP, July 19, 2004).

5. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered a worsening of his left shoulder condition that warrants a reopening of his claim. ATP Dr. Fox credibly explained that Claimant's left shoulder arthroplasty is in place and continues to function properly. He thus concluded that Claimant remained at MMI. Dr. Ogsbury noted that an MRI revealed no abnormalities in Claimant's brachial plexus but only abnormalities in the right shoulder joint and a syrinx formation. He thus remarked that, although it was possible that Claimant suffered a brachial plexus injury on October 9, 2003, the absence of left shoulder abnormalities suggested that no additional treatment would be necessary or helpful. Finally, Dr. Hemler agreed with Dr. Fox that Claimant's left shoulder was stable and that Claimant remained at MMI. He remarked that Claimant's persistent myofascial pain and left upper extremity numbness were attributable to the presence of the syrinx formation. In contrast, Dr. Hughes commented that Claimant suffered a worsening of condition as a result of progressive neuropathy. He attributed Claimant's symptoms to a possible C6 radiculopathy. However, Dr. Fox persuasively noted that in the six years of Claimant's treatment from 10 doctors, no other doctor had determined that Claimant sustained neck trauma on October 9, 2003 that caused a C6 radiculopathy. Claimant has therefore failed to demonstrate that he experienced a change in his physical condition that can be causally connected to his original compensable injury.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request to reopen his Workers' Compensation claim is denied and dismissed.

DATED: July 15, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-776-542

ISSUES

The issues for hearing were compensability, medical benefits, temporary total disability, independent contractor status, penalty for uninsured, and violation of safety rule. The parties stipulated that Dr. Christopher Hirose is authorized.

FINDINGS OF FACT

1. Claimant performed carpet cleaning duties for Employer. These duties included steam cleaning carpets and cleaning out air ducts on residential properties.

2. Kimbell, who is the owner of Employer, testified that he did not have the authority to fire workers. This testimony is contradicted by the testimony of Pinnell that Kimbell could fire workers, and did fire workers in the past. Pinnell credibly testified that he had been fired in the past by Kimbell. Employer would have no further liability to the fired worker. The ALJ resolves this evidentiary conflict in favor of Claimant, and finds that the weight and sufficiency of the credible evidence proffered establishes that Claimant could in fact be terminated at any time, for any reason, by Employer.

3. Checks were written to the Claimant personally. Employer paid Claimant individually, rather than throught a trade name.

4. Claimant's average weekly wage is $248.91.

5. Employees were required to drive Employer's vehicles to residential job sites. The employees were required to first check in with Employer at the main

office to determine what jobs needed to be done that day, and at what times. Claimant had checked into the office for the day prior to the accident. This injury occurred in the course and scope of Claimant's employment.

6. On June 28, 2008, Claimant was driving with a co-worker in a vehicle owned by Employer. The vehicle rolled over, ejecting Claimant. Claimant suffered traumatic injuries, and required transport by ambulance to Littleton Adventist Hospital. Claimant received emergency care. The treatment Claimant received after the injury is emergency treatment that is reasonable and necessary to treat the effects of the work-related injury. The parties stipulated that Dr. Hirose is authorized.

7. Employer did not carry workers' compensation insurance at the time of injury.

8. Claimant credibly testified that, during the time he worked for the employer, he was not customarily engaged in an independent trade or business. He testified credibly that he had no prior experience in air duct or carpet cleaning. Claimant also credibly testified that he had never operated a business in the past, nor did he operate under a trade name. Although Claimant was not required to work exclusively for Employer, he was not customarily engaged in an independent trade or business before or during the time he worked for Employer.

9. Employer did not establish a quality standard or oversee or instruct the actual work. Claimant was not paid a salary or at an hourly rate. Employer did not provide more than minimal training. Employer did not provide tools or benefits to Claimant. Employer did not dictate time of performance. Business operations of the Employer and Claimant were not combined.

10. Employer has not shown that it had a safety rule that Claimant violated or that the failure to use a seat belt resulted in more injuries than Claimant would have received had he been wearing the seat belt.

CONCLUSIONS OF LAW

12. Claimant was injured in a motor vehicle accident on June 28, 2008. At the time of the accident, Claimant was performing services for Employer for pay. Employer did not have worker's compensation insurance at the time of the accident.

13. Section 8-40-202(2)(a), C.R.S., provides that, "any individual who performs services for pay for another shall be deemed to be an employee" unless the person is "free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed." The putative employer may establish that the claimant was free from direction and control and engaged in an independent business or trade by proving the presence of some or all of the nine criteria set

forth in Section 8-40-202(2)(b)(II), C.R.S. *See Nelson v. Industrial Claim Appeals Office*, 981 P.2d 210 (Colo.App. 1998).

14. Factors that indicate that Claimant was an employee at the time of the accident are: (1) Although Claimant was not required to work exclusively for Employer, he was not customarily engaged in an independent trade or business before or during the time he worked for Employer (Factor A); (2) Employer could terminate Claimant at any time without liability (Factor D); and (3) Employer paid Claimant personally, instead of through a trade or business name (Factor E).

15. Factors that indicate that Claimant was not an employee at the time of the accident are: (1) Employer did not establish a quality standard or oversee or instruct the actual work (Factor B); (2) Claimant was not paid a salary or at an hourly rate (Factor C); (3) Employer did not provide more than minimal training (Factor E); (4) Employer did not provide tools or benefits to Claimant (Factor F); (5) Employer did not dictate time of performance (Factor G); and (6) Business operations were not combined (Factor I).

16. In order to be customarily engaged in an independent business, the worker must actually and customarily provide similar services to others at or near same time he works for the putative employer. *Carpet Exchange v. Industrial Claim Appeals Office*, 859 P.2d 278 (Colo.App. 1993); *See also, Long View Systems Corp. USA v. Industrial Claim Appeals Office*, 197 P.3d 295, 299-300 (Colo.App. 2008); *Valdez v. Wetherbee Drywall*, W.C. No. 4-732-329 (ICAO, April 28, 2009).

17. Claimant has established by a preponderance of the evidence that, at the time of the accident, he was performing a service for Employer for pay. Considering all the factors, it is found and concluded that Employer has not established that Claimant was an independent contractor at the time of the accident. The claim is compensable.

18. Claimant's benefits may be reduced under Sections 8-42-112(1)(a) or (b), C.R.S., where there is a violation of a safety rule resulting in the injuries suffered. There was no credible persuasive evidence adduced at hearing that Claimant violated a safety rule that led to the injuries he suffered. The ALJ further finds that no credible persuasive evidence was adduced at hearing that Claimant's injuries resulted from the willful failure to use a safety device. Consequently, Claimant's benefits may not be reduced pursuant to Sections 8-42-112(1)(a) or (b), C.R.S.

19. Claimant received emergency care on the date of the injury, for which the Employer is liable under Section 8-42-101(1) & (3), C.R.S. The bills for such care shall not exceed the Division of Workers' Compensation fee schedule. Dr. Christopher Hirose is authorized, and the Employer is liable for the costs of the care Claimant receives from him to cure and relieve the effects of the compensable injuries in amounts not to exceed the Division of Workers' Compensation fee schedule. Sections 8-42-101(1) & (3), C.R.S. Medical care providers may not seek to recover costs and fees from the Claimant. Section 8-42-105(4), C.R.S.

20. Claimant's average weekly wage is $248.91.

21. Temporary disability benefits are increased fifty percent due to Employer's failure to insure. Section 8-43-408(1), C.R.S. Temporary benefits are payable at the rate of $248.91 per week. Claimant is entitled to temporary total disability

benefits commencing on June 28, 2008, and continuing until terminated pursuant to law. Sections 8-42-105(1) & (3), C.R.S. Employer is liable for interest at the rate of eight percent per annum on any benefits not paid when due.

22. Employer must pay a deposit or post a bond in the amount of unpaid compensation and benefits. Section 8-43-408(2), C.R.S. No evidence as to the amount of the medical expenses was introduced. The bond will be set based the approximate amount of temporary disability benefits through the date of the hearing and interest through the date of this order.

ORDER

It is therefore ordered that:

1. Employer shall pay all reasonable and necessary medical expenses incurred by Claimant for treatment by Dr. Hirose and Littleton Adventist Hospital for the Claimant's work-related injury.

2. Employer shall pay Claimant temporary total disability benefits, increased for failure to insure, at the rate of $248.91 from June 28, 2008, and continuing until terminated pursuant to law. Employer shall pay Claimant interest at the rate of eight percent per annum on all compensation not paid when due.

3. In lieu of payment of the above compensation and benefits to Claimant, Employer shall:

a. Deposit the sum of $10,500.00 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/ Trustee. The check shall be mailed to the Division of Workers' Compensation, Attention: Sue Sobolik/Trustee, P.O. Box 300009, Denver, Colorado 80203-0009; or

b. File a bond in the sum of $10,500.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:

(1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or

(2) Issued by a surety company authorized to do business in Colorado.

The bond shall guarantee payment of the compensation and benefits awarded.

IT IS FURTHER ORDERED: That Employer shall notify the Division of Workers' Compensation of payments made pursuant to this order.

IT IS FURTHER ORDERED: That the filing of any appeal, including a petition to review, shall not relieve Employer of the obligation to pay the designated sum to the trustee or to file the bond. C.R.S. § 8-43-408(2).

4. All matters not herein decided are left open.

DATED: *July 15, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

ISSUES

- Did claimant prove by a preponderance of the evidence that a baseline average weekly wage of $753.76 more fairly approximates his wage loss and diminished earning capacity resulting from the injury?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Claimant worked some 10 years for employer as a maintenance worker. Claimant sustained an admitted injury while working for employer on May 22, 2007. Insurer filed a General Admission of Liability, admitting liability for compensation benefits based upon an average weekly wage (AWW) of $666.42. Insurer calculated this AWW based upon claimant's earnings over a 14-week period prior to his injury, during which claimant's hourly wage was $19.38. Pam Goodman is employer's director of human resources.

When working for employer, claimant was on call 24 hours per day and available by radio to address maintenance problems as they arose. On claimant's anniversary date of May 19, 2007, employer increased his hourly wage from $19.38 to $20.35. Although employer considered claimant a full-time employee, his hours fluctuated between 31 and 45 per week during the 52-week period prior to his injury. During the 52-week period prior to his injury, claimant averaged 37.04 hours per week.

The Judge credits the testimony of claimant and Ms. Goodman in finding: Had the injury not intervened, claimant likely would have continued to work the same amount of hours as he had worked during the 52-week period prior to his injury. Because of an unrelated health problem, claimant requested reduced work hours in March of 2006. Claimant however was unable to reduce his schedule to 4 days per week until January of 2007. The hours claimant worked during the 14-week period prior to his injury were markedly reduced when compared to those he worked prior to January of 2007. The Judge finds that the hours claimant worked during the 52-week period prior to his injury more likely demonstrates claimant's earning capacity, which has been diminished because of the injury.

Claimant showed it more probably true than not that an AWW of $753.76 more fairly approximates his wage loss and diminished earning capacity resulting from the injury of May 22, 2007. The Judge calculates this AWW based upon 37.04 hours per week multiplied by claimant's hourly rate of $20.35 (37.04 x $20.35 = $753.76). At the time of his injury, claimant demonstrated the capacity to earn $20.35 per hour. As found, claimant likewise demonstrated the capacity to work an average of 37.04 hours per week. Claimant's capacity to earn $20.35 per hour and to work an average of 37.04 hours per week has been diminished by the effects of his injury.

Employer provided claimant health insurance, including medical, dental, vision, and life insurance coverage as part of his fringe benefit package. Employer paid the premium costs on claimant's insurance through the date of his termination on November 30, 2007. The parties stipulated that claimant's monthly cost to continue his health insurance coverage under the Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA) is $404.38 ($93.32 per week).

Claimant elected not to obtain continuing health coverage under COBRA. Claimant instead elected to continue his health coverage under the plan of his ex-wife, who also worked for employer. Claimant's ex-wife covered him under her health plan through employer from December 1, 2007, through May 31, 2008, when she terminated her employment. Claimant's monthly premium cost to continue his health insurance coverage from December 1, 2007, through May 31, 2008, was $178.00 ($41.08 per week). Claimant's compensation benefits during the period of December 1, 2007, through May 31, 2008, should be based upon and AWW of $794.84 ($753.76 + $41.08 = $794.84).

The COBRA replacement cost of $93.32 per week more likely represents claimant's cost of conversion to a similar or lesser health plan after May 31, 2008, because claimant was no longer eligible to continue his coverage under his ex-wife's employer-provided health plan. Claimant's compensation benefits from June 1, 2008, ongoing, should be based upon and AWW of $847.08 ($753.76 + $93.32 = $847.08).

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues he has proven by a preponderance of the evidence that an AWW of $753.76 more fairly approximates his wage loss and diminished earning capacity resulting from the injury. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to

a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

The ALJ must determine an employee's average weekly wage (AWW) by calculating the money rate at which services are paid the employee under the contract of hire in force at the time of injury, which must include any advantage or fringe benefit provided to the employee in lieu of wages. *Celebrity Custom Builders v. Industrial Claim Appeals Office*, 916 P.2d 539 (Colo. App. 1995). Section 8-42-102(3), *supra*, grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective of calculating AWW is to arrive at a fair approximation of claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997).

Section 8-40-201(19)(b), *supra*, requires calculation of an injured employee's AWW to include:

> [T]he amount of the employee's cost of continuing the employer's group health insurance plan and, upon termination of the continuation, the employee's cost of conversion to a similar or lesser insurance plan ….

The purpose of §8-40-201(19)(b) is to ensure that the employee will have funds available to purchase coverage. *Schelly v. Industrial Claim Appeals Office*, 961 P.2d 547 (Colo. App. 1997). A claimant's AWW shall include the cost of continuing the employer's health coverage pursuant to COBRA, and, when that coverage ends, the cost of converting to similar or lesser coverage. *Stegman v. Sears*, W.C. No. 4559482 & 4483695 (ICAO July 27, 2005). In *Schelly v. Industrial Claim Appeals Office*, *supra*, the court held that claimant's cost of converting her coverage to Medicare after the COBRA period expired was properly included in her AWW. Thus, where a claimant eventually purchases similar or lesser health insurance individually, or through a different employer or Medicare, then the AWW should be adjusted accordingly, as should the benefit amount for the remainder of the benefit period. *Sears Roebuck & Co. v. Industrial Claim Appeals Office*, 140 P.3d 336 (Colo. App. 2006).

Here, the Judge found that claimant showed it more probably true than not that an AWW of $753.76 more fairly approximates his wage loss and diminished earning capacity resulting from the injury of May 22, 2007. Claimant thus proved by a preponderance of the evidence that his AWW is $753.76.

As found, claimant demonstrated the capacity to earn $20.35 per hour and to work an average of 37.04 hours per week. Claimant's injury has diminished claimant's capacity to work an average of 37.04 hours per week and to earn $20.35 per hour.

The Judge found claimant's cost to continue his health insurance coverage from December 1, 2007, through May 31, 2008, was $41.08 per week. Claimant's compensation benefits during the period of December 1, 2007, through May 31, 2008, should be based upon and AWW of $794.84. The Judge further found that the COBRA

replacement cost of $93.32 per week more likely represents claimant's cost of conversion to a similar or lesser health plan after May 31, 2008. Claimant's compensation benefits from June 1, 2008, ongoing, should be based upon and AWW of $847.08.

The Judge concludes that insurer should pay claimant compensation benefits based upon an AWW of $753.76 during the period of time from May 23, 2007, through November 30, 2007. Insurer should pay claimant compensation benefits based upon an AWW of $794.84 during the period of time from December 1, 2007, through May 31, 2008. Insurer should pay claimant compensation benefits based upon an AWW of $847.08 during the period of time from June 1, 2008, ongoing.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Insurer shall pay claimant compensation benefits based upon an AWW of $753.76 from May 23, 2007, through November 30, 2007.

2. Insurer shall pay claimant compensation benefits based upon an AWW of $794.84 from December 1, 2007, through May 31, 2008.

3. Insurer shall pay claimant compensation benefits based upon an AWW of $847.08 from June 1, 2008, ongoing.

4. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

5. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: July 16, 2009

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-728-088

ISSUES

The issues for determination are compensability (Respondents seek to withdraw their admissions), permanent partial disability benefits, and post maximum medical improvement (MMI) medical benefits.

FINDINGS OF FACT

1. Claimant began working for Employer as a paratransit driver on April 24, 2006. Claimant alleges a right shoulder injury as a result of falling while loading a wheelchair at work on April 19, 2007.

2. On April 19, 2007, at the end of her shift, Claimant reported to her supervisor, Cops, that she was experiencing sharp pain in her right arm. She stated that she was unsure how or when any injury had occurred and thought that perhaps loading three wheelchairs earlier that day caused her delayed pain. Claimant declined immediate medical attention, and stated that a visit to a doctor the following day would be fine.

3. That same day, Claimant completed an incident report in which she stated that she had sharp pain in her right arm. She stated that she could have hurt it that morning and it didn't take affect until about 2:00 p.m.

4. On April 20, 2007, Crown, Employer's safety manager, completed a Supervisor Investigation Report and noted that Claimant was unsure sure when or how her injury happened.

5. Claimant was referred to Mile Hi Occupational Medicine, P.C., where she saw physician assistant Downs on April 20, 2007. Claimant reported that she felt the onset of right shoulder and chest pain at about 11:00 a.m. the day before. She stated that at about 9:30 a.m., she was pulling and pushing wheelchairs and felt some soreness in the right chest and shoulder and right arm, but this was not "too bad". She continued to work, but at about 11:00 a.m., she noted a sharp, strong pain in the right chest and shoulder, which "almost buckled her over". She recovered and was able to continue to work. On physical exam, P.A. Downs noted that there was no ecchymosis or edema in the anterior right chest region nor in the neck, shoulder, or right arm. P.A. Downs did not assign work restrictions and allowed Claimant to continue working full duty.

6. Claimant returned to P.A. Downs on April 30, 2007, and reported that she had "no pain in the shoulder", but still very limited range of motion. P.A. Downs continued Claimant's full duty status, but recommended an MRI of Claimant's right shoulder.

7. Claimant had an MRI of her right shoulder on May 16, 2007, which showed a type III acromion, a central rotator cuff tendinosis exacerbated by a moderate "U-shaped" full-thickness tear of the distal supraspinatus tendon and some of the distal anterior fibers of the infraspinatus tendon. The torn supraspinatus tendon stump was retracted proximally over the mid superior humeral head and associated with mild fatty muscle atrophy. There was tendinosis, focal fraying, and a short partial tear of the long head of the biceps tendon. There was also a synchronous tear of the superior labrum with propagation into the biceps tendon anchor compatible with a type IV SLAP lesion.

8. On May 18, 2007, Claimant reported to P.A. Downs that she had "no pain" in her shoulder except when she tried to lift it overhead. P.A. Downs noted the results of the May 16, 2007, MRI and provided work restrictions and a referral to an orthopedist.

9. Claimant saw surgeon Dr. Michael Hewitt on June 1, 2007. Claimant reported that on April 19, 2007, she tripped over a wheelchair and fell onto her right shoulder. She denied a previous history of right shoulder injury and complained of a constant ache within the shoulder and the inability to raise her arm over her head. Dr. Hewitt recommended surgical intervention, and on July 10, 2007, performed a right shoulder rotator cuff repair, subacromial decompression, arthroscopic biceps tenodesis, and partial synovectomy of the glenohumeral joint.

10. On July 23, 2007, Respondents filed a General Admission of Liability based on Dr. Hewitt's surgery for her right shoulder. That admission noted that Claimant had no lost time prior to her July 10, 2007, surgery.

11. On April 9, 2008, Dr. Hewitt performed a second surgery, a right shoulder arthroscopic debridement, subacromial bursoscopy with lysis of adhesions, and manipulation under anesthesia. During surgery, the rotator cuff was inspected with no evidence of partial or full-thickness tearing.

12. On July 7, 2008, P.A. Downs referred Claimant to Dr. John Burris at Concentra Medical Centers (which had bought out Mile Hi Occupational Medicine, P.C.). On July 22, 2008, Claimant reported to Dr. Burris that on April 19, 2007, she was placing a wheelchair client onto the bus when she fell over the wheelchair and subsequently developed right shoulder pain.

13. On August 18, 2008, Claimant saw neurologist Dr. Alexander Zimmer for electriodiagnostic testing. Claimant reported that on April 19, 2007, she fell off the step of her bus, landing towards the right with her arms forward. He concluded that Claimant's pain and restricted motion in the right shoulder was not associated with neuropathy, plexopathy or radiculopathy.

14. On August 19, 2008, Dr. Burris placed Claimant at maximum medical improvement for her April 10, 2007, right shoulder injury. He assigned a 8% extremity rating for right shoulder loss of range of motion, which would convert to a 5% whole person rating.

15. On September 23, 2008, Respondents filed a Final Admission of Liability admitting for Dr. Burris' 8% extremity rating. Claimant objected and requested a Division IME.

16. On November 17, 2008, Dr. Barton Goldman performed the Division IME. Claimant reported that on April 19, 2007, she was pushing a wheelchair onto the wheelchair lift of her bus and, when she went to step off the lift, she fell forward onto the

street. She reported that her right arm was flexed and externally rotated and that she scraped her knuckles on both hands and her knees. Dr. Goldman noted that physical exam was non-focal, "rather diffuse", and subjective. He stated that the only focal sign was modestly elevated right triceps deep tendon flexion, which did not correlate with normal electrodiagnostic studies or the records. Claimant specifically denied any prior shoulder injury or discomfort and Dr. Goldman noted that he had no records regarding any pre-existing treatment.

17. Dr. Goldman agreed that Claimant was at maximum medical improvement as of August 19, 2008. He assigned an 18% right upper extremity rating for range of motion deficits, which would convert to an 11% whole person rating. He specifically stated that there was no basis for a diagnosis based impairment from Table 17 to the degree that there was no claviculectomy, nor any obvious crepitus or *other* conditions that would merit diagnosis based impairment.

18. In regards to Claimant's neck symptoms, Dr. Goldman noted that this was only sporadically mentioned in the records, and generally noted as mild. He felt it was important to note that her neck symptoms presented in an escalating fashion, not only towards the end of active medical treatment, but in the presence of what appeared increasing somatization. Dr. Goldman opined Claimant's more recent complaints of neck pain were "very likely" a mixture of referred myofascial pain from her right upper trapezius, somatization, and possibly secondary gain issues.

19. On January 27, 2009, Respondents filed an Amended Final Admission of Liability admitting for Dr. Goldman's 18% extremity rating and for post-MMI medical benefits. Claimant objected and filed an Application for Hearing endorsing the issues of permanent partial disability, conversion to whole person, permanent total disability benefits, and Grover medical benefits.

20. On February 11, 2009, Claimant saw Dr. John Hughes for a claimant's IME. Claimant reported to Dr. Hughes that she was injured in the course of putting a wheelchair client on a lift. Claimant reported that the client was in a table wheelchair, which made it awkward for her to step around the person, and that she tripped and fell forcibly on her right side. Claimant reported that she recalled having scrapes on her knee and hand and tearing her pants. Claimant reported no history of shoulder problems or injuries prior to April 19, 2007.

21. Dr. Hughes recommended a 21% extremity rating for right shoulder range of motion as well as an additional 10% extremity rating for "other factors" based on the November 2008 *Impairment Rating Tips*, resulting in a 29% upper extremity rating. He felt that Claimant's loss of function extended beyond the region of the right shoulder and recommended assignment of a 17% whole person rating.

22. On March 11, 2009, Claimant saw Dr. Greg Reichhardt for a respondents' IME. Claimant reported to Dr. Reichhardt that on April 19, 2007, she was putting a client on a wheelchair lift, and that after she locked the client in, she turned and fell and scraped her hands and knees. Dr. Reichhardt noted that Claimant initially

reported her mechanism of injury was pushing and pulling wheelchairs, with a later onset of shoulder pain, and that Claimant later reported onset of pain after a fall. Dr. Reichhardt noted that Claimant's later history was not consistent with the initial report of her April 19, 2007, injury.

23. Dr. Reichhardt noted that Claimant demonstrated significant pain behavior and that there were non-physiologic aspects to her presentation. He noted she had an inconsistent history, with a dramatically inconsistent history in regards to how her shoulder pain developed. Based on these concerns, he felt it was important to utilize the most valid range of motion measurements, and felt it was probable that Claimant's best range of motion measurements represented her most valid range of motion measurements. Therefore, he felt the measurements obtained by Dr. Burris on August 19, 2008, should be used for permanent impairment, and agreed with his recommendation for an 8% upper extremity rating. He felt there was no indication for provision of additional impairment.

24. On March 17, 2009, Claimant saw Dr. Burris for a one-time evaluation. Dr. Burris noted that he now had the reports from the initial visits with P.A. Downs the day after Claimant's alleged injury. Dr. Burris stated that the description of the history as well as P.A. Downs' examination was wholly inconsistent with Claimant's present reported history. Dr. Burris noted that P.A. Downs' physical exam showed no evidence of trauma with no swelling or edema or ecchymosis in the arm, shoulder, neck, or chest. Dr. Burris noted that the history and examination by P.A. Downs was inconsistent with a work-related rotator cuff tear. He opined that the findings on MRI showed significant impingement and a retracted rotator cuff tear indicating a chronic issue that pre-existed April 19, 2007. Dr. Burris stated that based on the new information available to him at that time, he felt the events described by Claimant the day after the alleged injury were not consistent with a rotator cuff tear. Therefore, he concluded that Claimant's present issues did not represent a work-related injury.

25. In regards to Claimant's functional limitations, Dr. Burris noted that Claimant's neck displayed full range of motion in all planes and was nontender. He noted that Claimant's right shoulder range of motion was approximately equivalent to the range of motion when he last saw her on August 19, 2008.

26. On April 8, 2009, Dr. Reichhardt provided a supplemental report addressing the issue of causation. Dr. Reichhardt stated that Claimant's initial presentation was not particularly suggestive of a rotator cuff tear, and that Claimant had an atraumatic onset of shoulder pain. Claimant was unsure initially of how she hurt her shoulder, and thought that it may have been when she was moving wheelchairs earlier that caused delayed pain. Dr. Reichhardt also noted that the MRI showed that the torn supraspinatus tendon stump was retracted proximally over the mid superior humeral head and was associated with mild fatty muscle atrophy, suggestive of a chronic tear. He felt that moving a wheelchair was not a typical mechanism of injury for a rotator cuff tear, and that combined with the uncertainty that Claimant initially reported in the incident reports about how she hurt her shoulder, and the inconsistencies in her reported

mechanism of injury over time to different providers, did not support a work-related injury in this case.

27. Based on Dr. Burris' opinion regarding causation, Respondents moved to add the issue of withdrawing their admission of liability. The parties agreed to hold the issue of permanent total disability in abeyance and proceed to hearing on the issue of compensability and permanent partial disability.

28. At hearing, Claimant testified that on April 19, 2007, after loading a client on the wheelchair lift, her shoestring got caught in the wheelchair, which caused her to fall on her right side. She testified that she fell with her right arm extended, and that as a result of the fall, she scraped her knuckles and knees, and hurt her shoulder. She testified that she got up after the fall and proceeded with her route.

29. At hearing, Claimant reviewed an incident report dated July 13, 2006. That report stated that while assisting a wheelchair client, Claimant's shoestring got stuck in the front tire of a wheelchair, and that she fell to the cement and scrapped her knees and fingers and tore her pants at the knee. Claimant testified that this was the correct incident report for her April 19, 2007, accident, but could not explain why the incident report dated April 18, 2007, (which was misdated by one day), failed to mention any such fall.

30. Claimant also testified that when she saw P.A. Downs on April 19, 2007, that she told him that she had fallen off the lift and scraped her knuckles and her knees. She speculated that P.A. Downs did not accurately document her injury because he must have been in a hurry to write something down.

31. Claimant testified that she was unsure of whether she had any prior medical treatment for her shoulders. However, on July 3, 1997, Claimant went to Denver Health and complained of left arm and shoulder pain. She reported that she played softball daily, but had no significant trauma. She was given an injection and returned for follow-up on July 18, 1997. On March 30, 1998, Claimant was seen at Denver Health with complaints of shoulder pain and that she could not lift her arms above her head. She reported that her condition started with coughing and sneezing. She also admitted she had been given pills for this condition seven years prior and complained of pain in the back of her neck. On July 10, 1998, Claimant again returned to Denver Health and reported shoulder pain, left greater than right, and inability to raise her arms above her shoulders. Claimant was instructed to follow-up with a neurologist and her primary care physician. Claimant then admitted to having this treatment but stated that it was "a long time ago." She stated that she only went to the hospital when she hurt, and testified that she did not report this treatment to Dr. Goldman, Dr. Hughes, or Dr. Reichhardt because they did not ask her about her medical history.

32. Claimant admitted that she played softball, and that she used to play "a lot." She testified that she was right handed, and that she played first base. Claimant testified that she had not played softball in five or six years, and specifically testified that she had not played since starting work for Employer. However, on June 5, 2006, two

months after starting her employment for Employer, Claimant went to Denver Health and complained of left toe pain that started after playing baseball the day before.

33. Cops, Employer's field supervisor, testified on April 19, 2007, at 6:00 p.m., at the end of Claimant's shift, during the process of checking out for the day, Claimant mentioned that she had pain in her right arm and that she may have hurt it on the job. In discussing Claimant's report of injury, Claimant was unable to tell Cops when or how the injury occurred, and that she was unsure of the mechanism of injury. Claimant stated that throughout the course of her day, she had picked up three wheelchair clients, and that *perhaps*, pushing those wheelchairs could have caused the pain in her arm. Cops inquired whether she required medical treatment at that time, and Claimant declined, stating that it would be fine if she saw a doctor the next day.

34. Cops testified that on April 19, 2007, Claimant did not report that she fell, and that, on his visual inspection of her at checkout from 18 inches away, he observed no signs of a fall, including scrapes or torn pants.

35. Dr. Hughes testified that the cause of Claimant's injury depended on the history of the mechanism of injury that was "deemed" correct. He noted that Claimant had given two descriptions of the injury, one of pushing and pulling wheelchairs, and one of falling after her shoestring got stuck in a wheelchair. Dr. Hughes also stated that Claimant's description of the injury given to him was not consistent with either of these histories, in that Claimant reported to him that she fell while loading a table wheelchair. Dr. Hughes testified that the different injuries described by Claimant would exert different forces on the shoulder, and admitted that it was important to obtain an accurate history of the mechanism of injury in forming a medical opinion. Dr. Hughes testified that he had not been given any records regarding Claimant's prior medical treatment for her shoulders.

36. Dr. Hughes testified that it was "hard to say" whether findings on Claimant's MRI were caused by the events of April 19, 2007, and stated that it was "quite possible" that the rotator cuff tear could have been pre-existing to April 19, 2007. However, he "suspected" that the tears of the tendon structure would have been accelerated by the events of April 19, 2007, and that either of the events described by Claimant "could have" caused progression of the rotator cuff tear.

37. Dr. Burris testified that when he started treating Claimant on July 22, 2008, he did not have her complete chart, and at that time, he did not question the cause of Claimant's right shoulder complaints. At that time, Claimant reported that she fell over a wheelchair while placing it on a lift. However, when Dr. Burris saw Claimant on March 17, 2009, he then had the records from Claimant's initial evaluation with P.A. Downs in which Claimant reported her injury resulted from pushing wheelchairs. Dr. Burris testified that the histories given by Claimant varied significantly, because falling on an outstretched arm would be a significant mechanism of injury, and that he would not expect the activities of pushing wheelchairs to cause rotator cuff pathology. He testified that when pushing wheelchairs, the shoulder is down by your side, a stable position, and would not put significant stress on the rotator cuff.

38. Dr. Burris also testified that the findings on Claimant's MRI were significant for pre-existing issues, and that the findings showed a process that had been ongoing for some time. He testified that Claimant's treatment at Denver Health in 1997 and 1998 was inconsistent with her denial of prior medical treatment to her providers, and that Claimant's complaints at those visits were consistent with the pre-existing nature of her problem. He opined that her problems had been around "for years", and that if Claimant engaged in certain activities, such as playing softball as described in the records, such overhead throwing would aggravate a pre-existing problem.

39. Dr. Burris testified that the history given by Claimant to P.A. Downs on April 20, 2007, of pushing wheelchairs was not consistent with causing a rotator cuff tear. Based on the Denver Health records, and Claimant's MRI, he opined that Claimant's rotator cuff tear was pre-existing, and that the activity of pushing a wheelchair would not aggravate Claimant's pre-existing problems.

40. Dr. Reichhardt testified that inconsistencies in Claimant's report of the mechanism of injury were significant because the types of injuries sustained while pushing wheelchairs during the course of a day and falling with an outstretched arm were very different. He noted that when Claimant initially reported her injury to Cops, she was unaware of what caused her problem. He noted that her initial speculation as to the cause of the injury, pushing wheelchairs, reported to Cops on April 19, 2007, was consistent with her report to P.A. Downs the next day. He felt these inconsistencies raised questions regarding the reliability of Claimant's history.

41. Dr. Reichhardt testified that the findings seen on Claimant's MRI showed that the rotator cuff tear was atrophied and retracted, indicating that the tear was chronic. He testified that the retracted rotator cuff and atrophy seen on MRI would take a number of months to occur because the changes occurred over time as a result of not having an intact rotator cuff. He testified that it was unlikely that Claimant would sustain a rotator cuff tear seen on the MRI as a result of pushing wheelchairs.

42. Dr. Reichhardt testified that Claimant's denial of prior treatment for her shoulders was inconsistent with the medical records. He noted that on March 30, 1998, and July 10, 1998, Claimant was having significant problems with her shoulders and that on her visits to Denver Health on those dates, it was clear she was having problems with both her shoulders. On March 30, 1998, she could not raise her arms above shoulder level, and on July 19, 1998, she was again unable to lift her arms above her shoulder. Dr. Reichhardt testified that these findings were indicative of underlying shoulder pathology and that Claimant's inability to raise her arms above her shoulder suggested that she had a rotator cuff tear or significant impingement at that time.

43. Dr. Reichhardt opined that Claimant's right shoulder condition was not caused or aggravated by her employment with Employer or the events of April 19, 2007. He stated that the pathology on the shoulder MRI was indicative of old pathology not likely to occur one month prior to the MRI, and therefore not likely related to the events of April 19, 2007. He also expressed concerns about Claimant's inconsistencies in her description of the mechanism of injury, as well as her initial report to her supervisor

that she was unsure of what caused her problem. He also noted that after the injury, Claimant was released to work full duty, suggesting Claimant was still able to function, after the events of April 19, 2007, despite her underlying shoulder pathology. Dr. Reichhardt also noted that Claimant had a number of non-physiologic findings on exam, with expanding symptom complex over time.

44. Dr. Reichhardt opined that Claimant would have required treatment for her right shoulder regardless of her work activities with Employer or the events of April 19, 2007, and that even if she wasn't aware of her symptoms, a rotator cuff repair would have been considered with or without her work-related incident.

CONCLUSIONS OF LAW

Respondents may prospectively withdraw an admission on the basis that it was erroneous or improvidently filed. *HLJ Management Group v. Kim,* 804 P. 2d 250 (Colo. App. 1990). The burden of proof to establish compensability remains on the claimant even when an employer or insurance carrier is seeking to withdraw an admission of liability. "It is well established that claimant must prove the existence of a compensable injury." *Pacesetter Corporation v. Collett*, 33 P.3d 1230, 1232 (Colo.App. 2001).

For a claim to be compensable under the Workers' Compensation Act (Act), a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. Section 8-41-301(1)(c), C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAO, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo.App. 2000); *Singleton v. Kenya Corp*., 961 P.2d 571, 574 (Colo.App. 1998). The question of causation is generally one of fact for the determination of the Judge. *Faulkne*r, 12 P.3d. at 846.

The Act distinguishes between the terms "accident" and "injury." The term "accident" refers to an unexpected, unusual, or undesigned occurrence. Section 8-40-201 (1), *supra*. By contrast, an "injury" refers to the physical trauma caused by the accident. Thus, an "accident" is the cause and an "injury" the result. *City of Boulder v. Payne*, 162 Colo. 345, 426 P.2d 194 (1967). No benefits flow to the victim of an industrial accident unless the accident results in a compensable injury. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo.App. 1990).

An increase in pain or other symptoms associated with a prior injury does not compel a finding that a claimant sustained a compensable aggravation or new injury. *F.R. Orr Construction v. Rinta*, 717 P.2d 965, 968 (Colo.App. 1985); *Martinez v. Monfort, Inc.*, W.C. No. 4-284-273 (ICAO, August 6, 1997); *Witt v. Keil*, W.C. No. 4-225-334 (ICAO, April 7, 1998); *Parra v. Ideal Concrete*, W.C. Nos. 3-963-659 and 4-179-455 (ICAO, April 8, 1998). The mere fact that symptoms appear during an employment event does not

require a conclusion that the employment was the cause of the symptoms, or that the employment aggravated or accelerated a pre-existing condition. Instead, the appearance of symptoms may be the logical and recurrent consequence of a pre-existing condition. *Jiron v. Express Personnel Services*, W.C. No. 4-456-131 (ICAO, February 25, 2003); *F.R. Orr Construction v. Rinta*, 717 P.2d 965, 968 (Colo. App. 1985).

Compensability is not established unless a claimant proves the need for medical treatment is a "[N]atural and proximate consequence of the . . . industrial injury, without any contribution from a separate, causative factor." *Valdez v. United Parcel Serv.*, 728 P. 2d 340 (Colo.App. 1986). The failure to establish a causal connection between the injury and the need for medical treatment is fatal to a claim for compensation. *Kinninger v. Industrial Claims Appeal Office*, 759 P.2d 766 (Colo.App 1988). To establish the causation connection, a claimant must establish that the need for "medical treatment is proximately caused by the injury, and is not simply a direct and natural consequence of the pre-existing condition" or subsequent injury. *Merriman v. Indus. Comm.*, 210 P.2d 448, 450 (Colo. 1949); *Rockwell International v. Turnbull*, 802 P.2d 1182 (Colo.App 1990).

Dr. Burris and Dr. Reichhardt provided credible and persuasive medical opinions that Claimant's right shoulder problems were not caused or aggravated by her employment with Employer or the events of April 19, 2007. Dr. Burris testified that pushing a wheelchair would not cause or aggravate a rotator cuff tear because, when pushing a wheelchair, the arm remained in a stable position. Dr. Reichhardt testified that pushing a wheelchair would not likely aggravate a rotator cuff tear unless there was a significant struggle, which was not reported in this case.

In this claim there are many inconsistencies in Claimant's testimony. In addition, Claimant was not truthful when responding to questions concerning her medical history and sports activities. The issue of causation, even medical opinions involving causation, rest to some extent on the credibility of the Claimant and her statements concerning the history of the accident. *Cabral v. Landry's Restaurants, Inc.*, WC NO.: 4-693-007, (ICAO, May 11, 2007). Claimant gave inconsistent accounts of her medical history, sports activities, and the mechanism of injury, to the medical care providers. The mechanisms of injury described by the Claimant are not supported from a clinical perspective or the record evidence.

Claimant has failed to carry her burden of proving that she suffered a compensable injury. Claimant's initial report of the injury, Claimant's pre-existing medical treatment, and the findings on MRI which show a pre-existing condition, along with Claimant's credibility issues, make it unlikely that Claimant's right shoulder complaints were caused or aggravated by any work activities, including the events of April 19, 2007.

Claimant has failed to establish by a preponderance of the evidence that she was injured as a result of an accident or occupational disease on April 19, 2007. The claim is denied. Respondents' admissions are withdrawn. Claimant's request for disability benefits or medical benefits, other than those already paid, are denied.

ORDER

It is therefore ordered that Claimant's request for additional benefits is denied.

DATED: *July 16, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-708-689

ISSUES

Whether the opinion of the DIME physician on the issue of Claimant's permanent impairment has been overcome by clear and convincing evidence.

Whether the Claimant is entitled to medical benefits for payment of the billing from the authorized treating physician for a second evaluation of Claimant's permanent impairment.

Whether Claimant has proven, by a preponderance of the evidence, an entitlement to medical treatment to maintain Claimant's condition after MMI.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as a Senior Lead Machine Operator. On December 4, 2006 Claimant sustained an admitted injury resulting from a motor-vehicle accident. On that date, Claimant was driving his pick-up truck returning from a training seminar in Denver when his truck was rear-ended by another vehicle.

2. Claimant was initially treated at Penrose Hospital. He was then referred to Memorial Occupational Health Center and was examined by Dr. Bethany Wallace, D.O.

3. Dr. Wallace initially evaluated Claimant on December 7, 2006. Claimant's chief complaints were low back, neck and left wrist pain. Dr. Wallace obtained a history that Claimant had previously been involved in a rear-end accident in 2003 and was treated by his family physician, Dr. Zimmer. Dr. Wallace also obtained a history that Claimant had a previous back injury with treatment by a chiropractor. Dr. Wallace's impression of Claimant's injuries were "CTL" (cervical/thoracic/lumbar) strain and left wrist strain. Claimant was prescribed medications and physical therapy and placed on work restrictions.

4. Claimant returned to Dr. Wallace on December 22, 2006. Claimant complained of low back pain around the waist area with occasional shooting pain to the mid-calf level in the right leg.

5. Claimant continued under the treatment of Dr. Wallace through July 2007. Dr. Wallace referred Claimant to Dr. Jeffery Jenks, M.D. who performed three lumbar epidural steroid injections to address Claimant's complaints of low back and right leg pain.

6. On July 24, 2007 Claimant was evaluated by Dr. Miguel Castrejon, M.D. at Memorial Occupational Health. Dr. Castrejon became Claimant's authorized treating physician.

7. Claimant reached MMI on January 22, 2008 based upon the opinion of Dr. Castrejon that Claimant's condition had become stable. Dr. Castrejon evaluated Claimant on January 22, 2008 and referred him for range of motion testing of the lumbar spine for the purpose of impairment rating. As of the date of MMI, Claimant's neck and left wrist pain had resolved. At the time of Dr. Castrejon's evaluation on January 22, 2008 Claimant had mild tenderness over the right paralumbar musculature and occasional right lower leg symptoms.

8. At the date of MMI Dr. Castrejon's Final Impression of Claimant's condition was chronic lumbar spine strain superimposed upon underlying degenerative disk and joint disease with electrodiagnostic findings of chronic right L5 radiculopathy with reinnervation changes.

9. The initial range of motion study of Claimant's lumbar spine motion obtained by Dr. Castrejon was invalid as it failed to meet the validity criteria. Dr. Castrejon then scheduled Claimant for repeat range of motion testing. Respondents have denied Dr. Castrejon's billing in the amount of $432.75 for the repeat range of motion testing.

10. Following the repeat range of motion testing Dr. Castrejon assigned Claimant 17% whole person impairment for the lumbar spine consisting of 7% impairment under Table 53 of the AMA Guides and 11% for lumbar range of motion impairment.

11. Dr. Michael Janssen, D.O. performed a DIME on June 5, 2008. In connection with his DIME evaluation of Claimant, Dr. Janssen reviewed medical records dating from 2001 including records from Dr. Zimmer and records of Claimant's past chiropractic treatment. Dr. Janssen assigned Claimant 7% whole person impairment consisting of 5% impairment under Table 53 of the AMA Guides and 2% impairment for range of motion. Dr. Janssen noted that Claimant had had non-specific low back pain since the December 4, 2006 rear-end accident that had changed his life. Dr. Janssen agreed with the date of MMI assigned by Dr. Castrejon and felt no further intervention was necessary as Dr. Janssen did not find evidence of clinical pathology that would need further intervention (i.e. surgery).

12. On July 7, 2003 Claimant was the restrained driver of a vehicle that was rear-ended. Claimant sought treatment from Dr. Zimmer on July 17, 2003 for complaints

of low back, abdominal left lower quadrant, neck and rib pain. Dr. Zimmer diagnosed acute cervical/dorsal strain-sprain, secondary to motor vehicle accident.

13. Claimant continued treating with Dr. Zimmer for the July 7, 2003 motor vehicle accident through October 7, 2004. Dr. Zimmer evaluated Claimant on that date and noted only slight cervicothoracic dysfunction with some right scapular trigger point. Dr. Zimmer did not specifically note low back or right leg pain. Dr. Zimmer felt Claimant had reached MMI and did not have any permanent partial disability as the result of the July 7, 2003 accident.

14. Claimant did not return to Dr. Zimmer for complaints of low back pain until April 24, 2006. On that date, Claimant complained to Dr. Zimmer of low back pain radiating down his right leg and into his groin. Dr. Zimmer diagnosed sacroiliitis and prescribed medications.

15. Claimant returned to Dr. Zimmer on August 11, 2006 for a re-check and complained that his hip and back were bothering him. On physical examination Dr. Zimmer noted no sacro-iliac joint tenderness and the hip was unremarkable. Dr. Zimmer's assessment was abdominal, hip and back pain. Dr. Zimmer instructed Claimant to return as needed or if he was not better. Claimant did not return to Dr. Zimmer until January 31, 2007 when he returned for a physical examination. At that time, Claimant had not been taking any of his medications because he had lost weight and had been working out.

16. In addition to Dr. Zimmer Claimant obtained chiropractic treatment beginning April 24, 2006 for complaints of low back pain, right hip and leg pain. Claimant was evaluated by the chiropractor on May 24, 2006 and decreased dorso-lumbar ranges of motion were noted. Claimant continued in chiropractic care until August 14, 2006.

17. Claimant testified that prior to the December 4, 2006 injury he did not have low back symptoms, right hip or groin pain, was not under any limitations and was not actively receiving treatment for low back complaints. Claimant further testified that prior to the December 4, 2006 injury he did not have any range of motion limitations in his low back. Claimant testified that since the December 4, 2006 injury it is now painful for him to bend over. The ALJ finds Claimant's testimony to be credible and supported by the medical evidence, and accordingly, Claimant's testimony is found as fact. Based upon Claimant's credible testimony, the ALJ finds that Claimant's low back, right hip, groin and leg were asymptomatic prior to the December 4, 2006 injury.

18. Dr. Janssen testified at deposition on October 28, 2008. Dr. Janssen initially testified that he did not see any suggestion nor had he obtained a history from Claimant that Claimant had chronic back, hip and leg pain prior to the injury of December 4, 2006. Dr. Janssen opined that from the history obtained from Claimant and the consistency of the complaints of pain since the December 4, 2006 injury, Claimant's back pain was causally related to the injury of December 4, 2006. (Janssen deposition, p. 17, l. 20 through p. 19, l.6).

19. Upon further questioning Dr. Janssen agreed that the medical records from prior to the December 4, 2006 injury showed similar symptoms as those presented by Claimant at the time of Dr. Janssen's DIME. It was pointed out to Dr. Janssen that these symptoms spanned a time frame from 2003 through August 2006 and he was asked if this could be termed a 'chronic' condition. Based upon this questioning, Dr. Janssen testified that this would be a definition of a chronic, ongoing condition. (Janssen deposition, p. 22, l.16 through p. 23, l.5). Upon additional questioning, Dr. Janssen stated his opinion that because Claimant had a chronic prior condition of his low back with previous limitations of motion Claimant had not sustained any permanent impairment related to the December 4, 2006 work injury. (Janssen deposition, p. 25, l.1 through p. 28, l.5). The ALJ finds that Dr. Janssen's ultimate opinion was that Claimant had not sustained any permanent impairment causally related to the December 4, 2006 injury.

20. Dr. Janssen's opinion that Claimant did not sustain any permanent impairment causally related to the December 4, 2006 injury because Claimant had similar symptoms of a chronic, ongoing nature prior to the 2006 injury is in error. As found, Claimant was asymptomatic prior to the 2006 injury, did not have limitations and was not receiving treatment for low back, right hip or leg symptoms. Claimant's condition had improved after August 14, 2006 to the point he was no longer symptomatic and no longer using the medications prescribed by Dr. Zimmer in April 2006. Claimant did not have chronic, ongoing low back, right hip or leg symptoms prior to December 4, 2006. The medical evidence establishes that after being placed at MMI in October 2004 for the July 2003 motor vehicle accident Claimant did not again complain of low back pain or seek treatment for such pain until April 2006.

21. The medical evidence establishes as a matter of fact that Claimant had not been found to have permanent impairment of his lumbar spine prior to the 2006 injury with Employer. Claimant specifically did not sustain any permanent impairment as a result of the 2003 motor vehicle accident. Dr. Zimmer had not provided Claimant a permanent impairment rating for his low back complaints in 2006 prior to the December injury.

22. Claimant has shown by clear and convincing evidence that the ultimate opinion of Dr. Janssen that Claimant did not sustain permanent impairment causally related to the December 4, 2006 injury was in error. Claimant has successfully overcome the ultimate opinion of Dr. Janssen, the DIME physician, on the issue of permanent impairment by clear and convincing evidence.

23. The ALJ finds that the original opinion of Dr. Janssen assigning Claimant 7% whole person impairment for low back pain and range of motion loss causally related to the December 4, 2006 injury is credible, persuasive and represents the more accurate assessment of Claimant's permanent impairment. The ALJ finds that Claimant sustained 7% whole person impairment as a direct result of the injuries and motor vehicle accident on December 4, 2006.

24. The repeat range of motion testing for which Claimant was referred by Dr. Castrejon in connection with his assessment of Claimant's permanent impairment was reasonable, necessary and causally related to the December 4, 2006 injury.

25. At the time Claimant was placed at MMI, Dr. Castrejon recommended maintenance care in the form of a continued home exercise program, access to prescription medications, repeat epidural steroid injections and physical therapy. Dr. Janssen's opinion that any further medical care is related to a chronic prior condition is not persuasive, for the reasons and factual findings set forth above. Claimant has had consistent low back and right leg symptoms since the December 4, 2006 injury that have continued. The ALJ resolves the conflict between the opinions of Dr. Castrejon and Dr. Janssen regarding the need for continued medical treatment after the December 4, 2006 injury in favor of the opinion of Dr. Castrejon. Claimant has proven, by a preponderance of the evidence, that he is in need of ongoing medical treatment to maintain the condition of his low back subsequent to the date of MMI.

CONCLUSIONS OF LAW

I.

GENERAL

26. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

27. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

1. **II.**

2. **THE DIME OPINION AND PERMANENT INPAIRMENT**

28. The DIME physicians' opinion consists not only of his written report but also any subsequent opinion given including the physicians' testimony at hearing. *Andrade v.*

Indus. Claim Appeals Office, 121 P.3d 328 (Colo. App. 2005); *Lambert & Sons, Inc. v. Indus. Claim Appeals Office,* 984 P.2d 656 (Colo. App. 1998). Where a DIME physician offers ambiguous or conflicting opinions concerning MMI the ALJ is to resolve the ambiguity and determine the DIME physicians' true opinion as a matter of fact. *Magnetic Engineering Inc., supra.* In so doing, the ALJ is to consider all of the DIME physicians' written and oral testimony. *Dazzio v. Rice & Rice, Inc.,* W.C. No. 4-660-140 (June 30, 2008). Once the ALJ determines the DIME physician's opinion, the party seeking to overcome that opinion bears the burden of proof by clear and convincing evidence. *Dazzio v. Rice & Rice, Inc.,* supra; *Clark v. Hudick Excavating, Inc.,* W. C. No. 4-524-162 (November 5, 2004). The burden of proof may shift in a situation where the deposition testimony of the DIME physician is considered as part of the DIME physician's overall "finding". *Stephens v. North & Air Package Express Services,* W. C. No. 4-492-570 (February 16, 2005).

29. Sections 8-42-107(8)(b)(III) and (c), C.R.S. provide that the finding of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indus. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

30. *Deleon v. Whole Foods Market, Inc.,* W.C. No. 4-600-477 (ICAO, November 16, 2006), addressed the proper evidentiary standard for determining a claimant's impairment rating after an ALJ finds that a portion of the DIME physician's impairment rating has been overcome by clear and convincing evidence. In the *Deleon* case the ALJ determined the respondents overcame by clear and convincing evidence a DIME physician's finding that the claimant sustained 5 percent impairment for lost range of motion in the lumbar spine. However, the ALJ also found that the respondents failed to overcome by clear and convincing evidence the DIME physician's finding that the claimant sustained 5 percent impairment for a specific disorder of the lumbar spine. Consequently the ALJ upheld the specific disorder portion of the rating. The ICAO ruled that once an ALJ determines "the DIME's rating has been overcome in any respect" the ALJ is "free to calculate the claimant's impairment rating based upon the preponderance of the evidence" standard. The ICAO further stated that when applying the preponderance of the evidence standard the ALJ is "not required to dissect the overall impairment rating into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence."

31. As found, Claimant has overcome the ultimate opinion of the DIME physician, Dr. Janssen, by clear and convincing evidence. Dr. Janssen's opinion that Claimant did not sustain any permanent impairment resulting from the December 4, 2006 injury is based upon Dr. Janssen's erroneous conclusion that Claimant had chronic,

ongoing symptoms of a similar nature prior to the December 4, 2006 injury. While Claimant did have low back and right hip symptoms prior to the December 2006 injury, those symptoms were not chronic and Claimant credibly testified that he was without symptoms and without any limitations on account of his low back prior to the December 2006 injury. Also as found, Dr. Janssen's original opinion that Claimant sustained 7% whole person impairment as a result of the December 4, 2006 injury is persuasive. Although Dr. Castrejon assigned 17% whole person impairment after obtaining valid range of motion measurements, Claimant has not proven by a preponderance of the evidence that Dr. Castrejon's rating more accurately describes Claimant's permanent impairment as opposed to the impairment rating provided by Dr. Janssen in his original report and opinion.

III.

LIABILITY FOR MEDICAL TREATMENT, THE REPEAT RANGE OF MOTION TESTING

1. 32. Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

2. 33. As found, Dr. Castrejon specifically scheduled Claimant for repeat range of motion testing after the initial testing was determined to be invalid. Respondents argue that Dr. Castrejon's charges for this testing represent unauthorized medical treatment. Respondents, however, do not dispute that Dr. Castrejon was an authorized treating physician. Dr. Janssen's opinion as deposition that Claimant did not require any further treatment for the December 4, 2006 injury is not dispositive or persuasive on the issue of Respondents' liability for further medical testing requested by the authorized treating physician to determine Claimant's permanent impairment upon Claimant reaching MMI.

3. **IV.**

4. **LIABILITY FOR MEDICAL TREATMENT AFTER MMI**

5. 34. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P.2d 701 (Colo. App. 1999). The claimant must prove entitlement to *Grover* medical benefits by a

preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature, subject to Respondents' right to contest compensability, reasonableness and necessity. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

6. 35. Claimant has proven by a preponderance of the evidence that medical treatment is necessary after MMI to maintain Claimant's condition related to the compensable injury. As found, the opinion of Dr. Castrejon regarding the need for treatment after MMI is more persuasive than the opinion of Dr. Janssen expressed at deposition or as expressed in Dr. Janssen's DIME report. Dr. Janssen's DIME report makes reference to "no further intervention" being necessary. The ALJ interprets this statement to refer more to the issue of MMI as opposed to the consideration of whether medical treatment is necessary to maintain Claimant's condition after MMI. As discussed above, Dr. Janssen's further opinion at deposition was based upon an erroneous conclusion concerning the status of Claimant's symptoms prior to the compensable injury, and therefore are not persuasive.

ORDER

It is therefore ordered that:

Insurer shall pay Claimant permanent partial benefits for 7% whole person impairment beginning on the date of MMI and continuing until paid in full. Insurer may take credit for any permanent partial benefits previously paid and for any temporary benefits paid after the date of MMI.

Insurer shall pay the bill of Dr. Castrejon in the amount of $432.75 for the repeat range of motion testing performed by Dr. Castrejon.

Claimant is entitled to a general award of medical benefits after MMI, subject to Respondents' right to challenge the reasonableness, necessity or causal relationship of any specific requested treatment. No specific treatment was at issue and none is awarded by this Order.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: July 16, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-723-976

ISSUES

The first issue to be determined is whether Joyce Mazza (hereinafter Claimant) suffered an injury to her cervical spine on March 21, 2007, which is compensable under the Colorado Workers' Compensation Act.

The second issue to be determined is whether the Claimant's condition was substantially aggravated in the July 16, 2007 assault such that it would be an intervening event that would relieve Respondent-Insurer of liability to treat her work related injuries.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ finds as follows:
At all times relevant to this matter, Claimant was employed by the Respondent-Employer. Claimant's job duties included direct patient contact, which occasionally required her to physically restrain patients.

On March 21, 2007, Claimant suffered injury to her neck and left shoulder area during an altercation at her place of employment with the Respondent-Employer. Immediately subsequent to the incident Claimant had some pain but felt it would get better.

However, Claimant's condition did not resolve and Claimant reported the injury to Respondent- Employer on May 17, 2007.

Claimant ultimately sought medical care and was eventually referred to the workers' compensation medical provider for the Respondent-Employer. Claimant saw Dr. Dallenbach, the authorized treating physician, who upon examination determined Claimant's injury to be work related. Claimant continued to treat with Dr. Dallenbach until Respondent-Insurer stopped paying medical benefits.

The ALJ finds that Claimant suffered an injury arising out of and in the course of her employment with Respondent-Employer on March 21, 2007. The Claim is compensable under the Workers' Compensation Act of Colorado.

On July 16, 2007 Claimant's ex-boyfriend assaulted her. Claimant was injured in the assault, however, after examining Claimant on July 26, 2007, and being apprised of the assault injuries, Dr. Dallenbach opined that Claimant did not suffer an exacerbation as a

result of the assault and that her then current complaints were work related. The ALJ finds Dr. Dallenbach's opinion to be the more credible medical evidence.

The ALJ finds that Claimant's work related condition was not substantially aggravated so as to be an intervening event that would relieve Respondent-Insurer of liability to treat her work related injuries.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P. 3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and action; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d1205 (1936); CJI, Civil 3:16 (2005).

3. Claimant shoulders the burden of proving by a preponderance of the evidence that his alleged injuries arose out of the course and scope of his employment with the employer. C.R.S. §8-41-301(1); *see*, *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. ICAO*, 12 P.3d 844 (Colo. App. 2000). A compensable injury is an injury which "arises out of and "in the course of" employment. C.R.S. §8-41-301; *Price v. Industrial Claims Appeal Office*, 919 P.2d 2007 (Colo.1996). An injury "arises out of" employment when the origins of the injury are sufficiently related to the conditions and circumstances under which the employee usually performs his or her job functions to be considered part of the employee's services to the employer. *General Cable Co. v. Industrial Claim Appeals Office,* 878 P2d. 118 (Colo.App.1994).

4. On March 21, 2007, Claimant suffered injury to her neck and left shoulder area during an altercation at her place of employment with the Respondent-Employer. The ALJ concludes that it is more likely than not that Claimant suffered an injury arising out of and in the course of her employment with Respondent-Employer on March 21, 2007. The Claim is compensable under the Workers' Compensation Act of Colorado.

5. The burden of proof in a workers' compensation case rests on the party who asserts the affirmative of an issue. *Valley Tree Service v. Jimenez,* 787 P.2d 658, 659 (Colo.App.1990); *Stampados v. Colorado D & S Enterprises, Inc.,* 833 P.2d 815, 817-818 (Colo.App.,1992).

6. Respondents assert that the work related condition was substantially aggravated by the July 16, 2007 assault, such that the assault represents an intervening event that would relieve Respondents of their liability to treat Claimant's work related injuries. As such, the burden of proof on this issue rests with Respondents.

7. The ALJ concludes that it is more likely than not that Claimant's work related condition was not substantially aggravated so as to be an intervening event that would relieve Respondent-Insurer of liability to treat her work related injuries.

ORDER

It is therefore ordered that:

1. Claimant suffered an injury arising out of and in the course of her employment with Respondent-Employer on March 21, 2007. The Claim is compensable under the Workers' Compensation Act of Colorado.

2. Claimant's work related condition was not substantially aggravated by the July 16, 2007 assault so as to be an intervening event that would relieve Respondent-Insurer of liability to treat her work related injuries.

3. Respondent-Insurer shall pay for all reasonable and necessary medical treatment to cure or relieve Claimant from the effects of her work related injury.

4. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

5. All matters not determined herein are reserved for future determination.

DATE: July 17, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-776-643

ISSUES

- Whether Claimant sustained an injury to his low back in the course and scope of his employment.
- Whether Claimant is entitled to medical benefits to treat the injury.
- Whether Claimant is entitled to temporary total (TTD) benefits.
- Average weekly wage (AWW).
- Respondent's oral motion to strike the issue of penalties for failure to admit liability contrary to the evidence was granted.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds as fact:

1. Employer hired Claimant on July 29, 2008 as a night grocery clerk. Claimant's immediate supervisor was Banes.

2. The store secretary, Viegel, interviewed Claimant for the position and discussed the shift requirements with Claimant. The position Claimant applied for required full flexibility. Claimant signed a form acknowledging the shift was from 10:00 p.m. to 6:30 a.m.

3. Claimant had asked Viegel if he could work only until 2:00 a.m. and Viegel's response was that Claimant might get lucky and only get scheduled until 2:00 a.m., but that there were no guarantees. On September 29, 2008, Claimant wrote a note addressed to "HR Department" stating that he needed to leave work by 2:00 a.m. every shift. Viegel called Claimant on September 30, 2008, to advise him that he was required to be available to work from 10:00 p.m. to 6:30 a.m.

4. Banes frequently scheduled Claimant only until 2:00 a.m., but he also scheduled Claimant until 4:00 a.m. on occasion. The week ending October 11, 2008, after Claimant wrote the note to HR described above, Banes scheduled Claimant to work

until 4:00 a.m. for three shifts. On the four Sunday-Monday shifts that preceded November 2, 2008, Claimant was scheduled to work until 4:00 a.m.

5. On Sunday, November 2, 2008, Claimant started his shift at 10:00 p.m. and clocked out at 2:18 a.m. The official schedule reflected that Claimant was scheduled to work until 6:30 a.m. on November 3, 2008. Claimant testified that he thought his shift ended at 2:00 a.m. based on a schedule posted in the employee lounge.

6. Banes noticed Claimant did not return from his lunch break during his November 2-3, 2008 shift. Claimant did not allege an injury to Banes or to any of his coworkers. Claimant clocked out and left without notifying anyone.

7. Sometime during his shift, Claimant slipped a note dated November 3, 2008, under Viegel's door stating that he had some lower back pain and he thought it was from pulling a pallet of water. He did not report this injury to Banes although Banes was working that shift. Viegel does not work the night shift and was not at the store when Claimant slid the note under her door.

8. Viegel found the note the following morning and gave it to a manager, but she could not recall which manager.

9. When Claimant arrived at work on November 3, 2008, Banes suspended Claimant for leaving work early during his prior shift. Claimant did not tell Banes he thought his shift ended at 2:00 a.m. or that he sustained an injury. Banes told Claimant not to come back to work until he had spoken to Dan, the Assistant Store Manager, or Don, the Store Manager.

10. The following morning Claimant contacted the store and spoke to the service manager, Bueter, about leaving early on November 3, 2008. He failed to explain the details to Beuter. Beuter was left with the impression there was a time card issue. Claimant did not tell Beuter he had been suspended from work or that he had a work related injury. Claimant asked Bueter if he could see a doctor listed in the employee lounge but did not advise Bueter he sustained an on the job injury. Bueter later learned of the injury and completed an incident report.

11. Claimant reported for work on November 4, 2008 and told Banes that Bueter allowed him to return to work. He then handed Banes his work restrictions. This was the first time Banes had learned that Claimant had alleged a work injury. Claimant told Banes that he had back pain from carrying "24-packs" of water. Banes allowed Claimant to work within the restrictions based on Claimant's assertion that Bueter approved it.

12. The assistant store manager, Stempnitzky, eventually learned that Claimant had left work early on November 3 without permission and had not discussed the matter with the appropriate management personnel before returning to work. Stempnitzky imposed a five-day suspension from work, which Claimant served through November

11, 2008. Claimant returned to work on modified duty following completion of the suspension.

13. Claimant chose Union Medical from the list of physicians in the employee lounge. On November 4, 2008, Claimant saw Dr. Shauna Wright. He reported to Dr. Wright that he was moving pallets of water and noted some pain in his mid back to the right. He denied radicular symptoms and lower extremity numbness, tingling or weakness. Claimant filled out a pain diagram, but did not mark burning in any part of his body despite the form presenting the option to do so. Dr. Wight referred Claimant for physical therapy and imposed work restrictions that included no lifting or carrying over 20 pounds, and no pushing or pulling over 30 pounds. Claimant declined prescription medications and elected to take only Advil as needed.

14. Claimant testified that when he began feeling low back pain during his work shift on November 2, 2008, he also felt burning in both of his legs, but more so in the left. However, Claimant denied radicular symptoms including lower extremity numbness, tingling or weakness when he saw Dr. Wright on November 4, 2008.

15. On November 7, 2008, Claimant saw the physical therapist and reported occasional radiating pain into the right leg. He reported that his low back pain increased in intensity while working and with heavier activities. Claimant reportedly had worked within his work restrictions and only for one or two shifts between November 3 and November 7.

16. On November 11, 2008, Claimant reported burning down his left lower extremity to Dr. Mark Paz.

17. Claimant testified he had no prior leg problems but in August 2007 he filed a workers' compensation claim for problems in the back of his legs.

18. Respondents ultimately denied Claimant's workers' compensation claim. On November 26, 2008, Employer advised Claimant that he could no longer work with the physical restrictions because they were due to a non-occupational injury. Employer advised Claimant he could request a medical leave of absence until a doctor released him to full duty. Claimant did not complete the forms and Employer eventually terminated his employment.

19. Based on the foregoing, Claimant has not established by a preponderance of the evidence that he sustained an injury to his low back while in the course and scope of his employment. Claimant's testimony lacked credibility and is not persuasive. Claimant's testimony was inconsistent with the medical records and his denial of prior leg pain. Claimant's testimony regarding his actions and events following the injury is not persuasive or credible.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge enters the following conclusions of law:

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A Claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

2. The facts in a workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *Colorado Jury Instructions, Civil*, 3:16.

4. Claimant must prove that he suffered an injury arising out of and in the course of employment which directly and proximately caused the condition for which benefits are sought §8-41-301(1), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999). It is claimant's burden to prove by a preponderance of the evidence that he is entitled to benefits**.** A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. § 8-43-201, C.R.S.

5. As found, Claimant has failed to establish by a preponderance of the evidence that he sustained an injury to his back while in the course and scope of employment. Claimant's testimony lacked credibility and was inconsistent with the medical records. For example, Claimant testified that when he began feeling low back pain during his work shift on November 2, 2008, also felt burning in both of his legs, but more so in the left. During his initial evaluation on November 4, 2008 with Dr. Wright, Claimant denied radicular symptoms including lower extremity numbness, tingling or weakness. In the pain diagram, Claimant did not mark burning in any part of his body despite the form presenting the option to do so. Claimant then saw a physical therapist on November 7, 2008 during which he reported occasional radiation of pain

into the right leg. He also reported that his low back pain increases with intensity while working and with heavier activities although he had been working within his restrictions. The medical records from Dr. Paz dated November 11, 2008, reflect that Claimant reported burning down the left lower extremity. Finally, Claimant testified he had no prior leg problems, but in August 2007 he filed a workers' compensation claim for problems in the backs of his legs. Due to the inconsistent statements, testimony, and lack of persuasive or credible evidence to support Claimant's contentions, Claimant's claim for workers' compensation benefits is hereby denied.

3. Because it is found this claim is not compensable, the remaining issues need not be addressed.

ORDER

It is therefore ordered that Claimant's claim for workers' compensation is denied and dismissed.

DATED: July 17, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-690-491

ISSUES

The following issues were raised for consideration at hearing:

A. Whether Respondents sustained its burden of proof to establish by clear and convincing evidence the Division independent medical examiner (DIME) opinion is most probably incorrect with regard to the determination that Claimant's neck condition is related to the work injury and was not at maximum medical improvement (MMI); and

B. Whether Claimant sustained his burden of proof to establish by a preponderance of the evidence that the DIME impairment rating for Claimant's shoulder should be converted to a whole person impairment rating.

FINDINGS OF FACT

Based on the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant is a credible witness and his testimony is both persuasive and consistent with the medical records in the case.

2. This is an admitted injury occurring on January 14, 2006.

3. At the time of his injury, Claimant was a forklift driver for the Employer. The forklift he was driving fell off the loading dock causing injury to Claimant's neck, wrist, and shoulder. Claimant was initially transported to Aurora South where he was evaluated for a left wrist fracture and underwent immediate surgery with Dr. Leversedge.

4. Shortly thereafter, Claimant noted left shoulder problems. He underwent surgery on his left shoulder on October 31, 2006, with Dr. Lee B. Grant. The surgery involved an arthroscopy of the subacromial bursa, acromioplasty, resection of coracoacromial ligament, and an open distal clavicle resection.

5. Throughout Claimant's treatment for his left shoulder, he noted pain radiating from his left hand into his neck and complained to his treaters about this. However, his neck pain was not treated.

6. The first doctor to acknowledge Claimant's neck complaints was Division independent medical examiner (DIME), Dr. Bachman, who saw Claimant on November 13, 2007. In his DIME report of that date, Dr. Bachman assessed Claimant to be at maximum medical improvement (MMI) for his wrist and shoulder, but not for his neck.

7. At a follow-up DIME on February 16, 2009, Dr. Bachman assessed Claimant at MMI and gave him a left upper extremity impairment rating for his wrist of 25% (LUE). Claimant does not dispute that this component of his injury should be paid as a scheduled rating under Section 8-42-107(2), C.R.S.

8. Dr. Bachman also accorded Claimant a cervical spine impairment of 19% whole person, and 22% LUE for his left shoulder. The doctor converted this shoulder rating to 13% whole person impairment .

9. Respondents' dispute Dr. Bachman's impairment rating of Claimant's neck arguing that his cervical spine problems were not adequately documented as part of Claimant's work injury. Respondents also argue that Claimant's left shoulder impairment should not be compensated as a whole person.

10. Dr. Bachman agreed that the medical documentation did not contain a written record of a neck injury. However, it was Dr. Bachman's credible and persuasive opinion that Claimant's initial failure to mention a neck problem at the time of his original hospitalization on January 14, 2006, was the result of the "severe distracting injury" to his left wrist. Claimant testified consistently with this.

11. Dr. Bachman also disputed the opinion of Dr. Allison Fall that he had failed to comply with the *AMA Guides to the Evaluation of Medical Impairment* (Third Edition) (Revised)(AMA Guides) by giving a neck rating without adequate documentation of the occurrence of an injury to Claimant's neck. Dr. Bachman opined that a rating for Claimant's neck was consistent with the doctor's review of the medical records and based on Claimant's complaints. Further, the MRI performed on May 8, 2008, after the initial DIME, documented the presence of cervical disc disease, which Dr. Bachman opined was consistent with the injury Claimant sustained on January 14, 2006. Accordingly, when he evaluated the Claimant on February 16, 2009, he determined that Claimant was entitled to a rating under the *AMA Guides* of 19% whole person for the cervical component of his injury.

12. Claimant testified that he continues to experience sharp pain to his left shoulder and into his neck area. Claimant testified as a result of his left shoulder injury he is unable to carry items on his left shoulder and cannot sleep on his left side. He also testified that rotation of his neck from right to left or left to right is inhibited by pain that he experiences at the base of his neck and on the left side and into his left shoulder. His cervical rotation limitation is greater when he is moving right to left. As a consequence of this limitation, when Claimant is in a vehicle without a rearview mirror, he must turn his body fully in order to see behind him.

13. Dr. Swarsen, testified for Claimant that his review of Dr. Bachman's two DIME reports when coupled with both the testimony presented at hearing and his review of Claimant's medical records, substantiated his opinion that Dr. Bachman had performed both his DIME evaluations, and his rating, consistently with both the AMA *Guides* and the instructions of the Division of Workers' Compensation DIME Unit.

14. Dr. Swarsen testified that the site of Claimant's functional impairment to his left shoulder is above the arm. Using the anatomical chart, he described the site of surgeries and testified that the pain the Claimant is experiencing was consistent with the nature of the surgery he had undergone. All surgeries were above the glenohumeral joint and to the shoulder girdle not the arm. He opined that Claimant's impairment was to his left shoulder, not his arm, and that the situs of Claimant's left shoulder functional impairment is to the shoulder, not the arm.

15. Dr. Swarsen's testimony is more credible and persuasive than the testimony of Dr. Fall concerning whether Claimant's shoulder injury should be converted to a whole person impairment rating because the situs of Claimant's left shoulder functional impairment is above the arm.

16. Dr. Swarsen also agreed with Dr. Bachman that a cervical rating was appropriate given the facts of this case and documented presence of pain for a period of time longer that six months as required by Table 53 of the AMA *Guides.*

17. The testimony and opinion of the DIME, Dr. Bachman, and Dr. Swarsen are found credible. The opinion of Dr. Fall is rejected.

18. All other issues are reserved as a matter of fact.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The Findings of Fact only concern evidence dispositive of the issues involved. Not every piece of evidence, which would lead to a conflicting conclusion, is included. Evidence contrary to the findings was rejected as not persuasive. *Magnetic Engineering, Incorporated v. ICAO*, 5 P.3d 385 (Colo. App. 2000); *Boyet v. Wal-Mart Stores, Incorporated*, WC 4-460-359 (ICAO August 28, 2001).

2. The purpose of the Act is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S.

3. A claimant in a workers' compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

4. The facts in a workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

5. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; and the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

6. A DIME physician's findings concerning medical impairment, MMI, and causation are binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(b)(III), C.R.S.; *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186-90, 189 (Colo. App. 2002). Whether a party has met the burden of overcoming a DIME by clear and convincing evidence is a question of fact. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411, 414 (Colo. App. 1995).

7. Clear and convincing evidence means "evidence which is stronger than a mere 'preponderance'; it is evidence that is highly probable and free from serious and substantial doubt." *Metro Moving & Storage Co v. Gussert, supra*, 914 P.2d at 414; *DiLeo v. Kotlnow*, 200 Colo. 119, 613 P.2d 318 (1980)).

8. In this regard, Respondents failed to sustain its burden of proof to establish that the DIME physician's opinion is most probably incorrect and is overcome by clear and convincing evidence. It is found that the testimony of Claimant, the testimony and medical reports of Dr. Bachman, and the testimony of Dr. Swarsen are credible and persuasive. Claimant credibly explained, and his testimony was supported by DIME Dr. Bachman, that his accident was one in which the neck complaints were overlooked because the wrist injury was so severe, even though Claimant reported his neck problems to medical personnel.

9. Therefore, it is concluded that the DIME Dr. Bachman's determination that Claimant suffered a neck injury as the result of his work related accident and a 19% whole person permanent impairment has not been overcome.

10. When an injury results in a permanent medical impairment not set forth on a schedule of disabilities, an employee is entitled to medical impairment benefits paid as a whole person. See Section 8-42-107(8)(c), C.R.S.

11. Whether a claimant has suffered the loss of an arm at the shoulder within the meaning of Section 8-42-107(2)(a), C.R.S., or a whole person medical impairment compensable under Section 8-42-107(8)(c), C.R.S., is determined on a case by case basis. *See DeLaney v. ICAO*, 30 P.3d 691 (Colo. App. 2000*); Martinez, supra; Keebler Company v. ICAO,* 02CA1391 (Colo. App. 2003) (NSOP).

12. Pain and discomfort, which limits a claimant's ability to use a portion of the body is considered functional impairment for purposes of determining whether an injury is off the schedule. *See Langton v. Rocky Mountain Healthcare Corp*., 937 P.2d 883 (Colo. App. 1996); *Eidy v. Pioneer Freightways*, W.C.# 4-291-940 (ICAO, August 4, 1998); *Beck v. Mile Hi Express, Incorporated*, W.C.# 4-238-483 (ICAO, February 11, 1997).

13. Here Claimant suffers pain at the top of his shoulder, which limits his ability to perform the function of carrying objects on his shoulder, lifting above the head, and sleeping. Claimant's functional impairment is above the arm and not on the schedule of impairments. *See Phase II Company v. ICAO*, 97 CA 2099 (Colo. App. September 3, 1998) (NSOP).

14. The ALJ concludes that the situs of Claimant's functional impairment from his left shoulder injury is above the arm. Thus, Claimant is entitled to a whole person rating of 13% established by the DIME physician.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the ALJ Orders that:

1. Respondents failed to overcome DIME Dr. Bachman's rating, MMI, and his opinion on causation.

2. Claimant is entitled to a 25% left upper extremity rating for his left wrist injury consistent with the opinion of DIME Dr. Bachman of February 20, 2009. For his wrist injury, Claimant has sustained a 25% upper extremity rating. which is to be compensated pursuant to the schedule found at Section 8-42-107 (2), C.R.S.

3. The opinions of Dr. Bachman concerning causation of the cervical component of Claimant's injury is found credible and the testimony of Dr. Fall is rejected.

4. Claimant is entitled to a 19% whole person impairment rating for the cervical component of his injury.

5. Dr. Swarsen's expert testimony that Claimant's shoulder injury should be converted to a whole person is found credible. Claimant has demonstrated that his shoulder injury should be compensated as a whole person. The testimony of Dr. Bachman establishes that the Claimant's 22% left upper extremity rating for his left shoulder should be converted to a 13% whole person.

6. Under the Combined Value tables of the *AMA* Guides (p. 254) Claimant's total whole person impairment for his neck and shoulder injuries is 30%, i.e. 13% whole person left shoulder and 19% whole person neck. For this he is entitled to compensation based on the statutory formula found at Section 8-42-107 (8)(d), C.R.S., of 30% x 400 x $697.20 TTD rate x 1.4 age multiplier = $117,129.60.

7. The combined impairment suffered by the Claimant exceeds 25% according to the DIME Dr. Bachman. Thus, the cap of $150,000.00 found at Section 8-42-107.5, C.R.S., shall apply based on a date of injury of January 14, 2006.

8. Interest shall accrue at the rate of 8% per anum for all benefits not paid when due.

9. Any issues not determined in this decision are reserved for future determination.

DATED: July 17, 2009

Margot W. Jones
Administrative Law Judge

ISSUES

- Whether Claimant is entitled to temporary total disability (TTD) benefits commencing on December 27, 2008.
- Whether Claimant was responsible for termination of her employment.
- The parties stipulated that Claimant's average weekly wage (AWW) is $379.20.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds as fact:

1. On October 2, 2008, Claimant sustained an injury to her low back at work lifting a tray of bread. Following the injury, Claimant returned to work with Employer. Claimant missed no time from work due to her injury.

2. Claimant described her job as working as a cashier and helping customers, cleaning the inside of the bread display, sorting the bread display and covering the bread at night. Claimant did not explain whether these job duties were pre-injury or post-injury.

3. The medical records reflect that on December 8, 2008, Claimant saw Dr. George Kohake who imposed work restrictions as follows: No lifting over 20 pounds, no bending greater than 10 times per hour, no pushing and/or pulling over 30 pounds of force. Claimant agreed that these restrictions were in place since the date of injury and that she was able to work within them. Claimant did not explain whether these restrictions required her to modify her normal pre-injury job duties.

4. On December 27, 2008, the Employer terminated Claimant. The Claimant's supervisor asserted that on December 24, 2008, the Claimant and a co-worker, Juereca, failed to assist a customer. Claimant returned to work on December 26. On December 26, the Claimant was given a written warning pertaining to the incident on December 24. The Claimant refused to sign the written warning because the Claimant disagreed that she had failed to assist the customer, explaining that it was Juereca that had done this, and because her supervisor refused to explain the written warning to her. Claimant's supervisor sent her home and told her she could not return to work until she spoke to the district manager or the store director. Claimant met with the store director the following day at which time he fired her.

5. The district manager testified that Claimant was not fired for refusing to sign the warning rather Claimant abandoned her job by leaving the management office during the meeting with the store director. The Claimant testified the store director had sent her home when she would not sign the warning and fired her. The district manager was not present at the store for any of the events described herein.

6. Claimant's primary authorized treating physician, Dr. John Burris, placed Claimant at maximum medical improvement on March 9, 2009, with no permanent work restrictions.

7. Claimant underwent an independent medical examination with Dr. Edwin Healey on May 6, 2009. Dr. Healey concluded that Claimant was, "not able to resume the full activity that she was able to perform prior to the October 2, 2008, injury and is, thus, entitled, along with her chronic pain, to an impairment rating." Dr. Healey's report contains no description of Claimant's job duties or an opinion about whether Claimant could perform her normal job duties as of December 27, 2008.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge enters the following conclusions of law:

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

Responsibility For Termination

Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., (termination statutes) provide that, where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury. Respondents shoulder the burden of proving by a preponderance of the evidence that

Claimant was responsible for her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000).

By enacting the termination statutes, the General Assembly sought to preclude an injured worker from recovering temporary disability benefits where the worker is at fault for the loss of regular or modified employment, irrespective whether the industrial injury remains the proximate cause of the subsequent wage loss. *Colorado Springs Disposal v. Martinez*, 58 P.3d 1061 (Colo. App. 2002) (court held termination statutes inapplicable where employer terminates an employee because of employee's injury or injury-producing conduct). An employee is "responsible" if the employee precipitated the employment termination by a volitional act which an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995). That determination must be based upon an examination of the totality of the circumstances. *Id.*

However, if a claimant is terminated for fault, and a work related injury contributes in some degree to the subsequent wage loss, the claimant remains eligible for TTD benefits. *Bestway Concrete v. Industrial Claim Appeals Office,* 984 P.2d 680 (Colo. App. 1999). However, a claimant does not act “volitionally,” or exercise control over the circumstances leading to the termination if the effects of the injury preclude performance of her assigned duties and cause or contribute to the termination. *Eskridge v. Alterra Clarebridge Cottage, W.C. No. 4-651-260 (April 21, 2006).* The question as to whether a claimant acted volitionally is one of fact and is upheld if supported by substantial evidence. *Id.*

Respondents have not established by a preponderance of the evidence that Claimant was responsible for her termination from employment within the meaning of the termination statutes in the Workers’ Compensation Act. The district manager testified that Claimant was not fired for refusing to sign the warning rather he testified that Claimant abandoned her job by leaving the management office during the meeting with the store director. The district manager was not present at the store for any of the events that led to the termination. His testimony was based solely on third party hearsay statements. Accordingly, Claimant’s testimony regarding the termination of her employment is more credible and persuasive than that of the district manager. Based upon the totality of the circumstances, Claimant did not commit a volitional act that led to the termination and did not exercise a sufficient degree of control over the circumstances of her termination. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., do not bar Claimant from receiving temporary disability benefits.

Entitlement to Temporary Total Disability

To prove entitlement to TTD benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), C.R.S., requires a claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform her regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

Claimant has not established that her work injury has impaired her earning capacity despite or that any disability arising out of the injury resulted in an actual wage loss. While it is true that Claimant's authorized treating physician had imposed physical restrictions, Claimant has not shown that these restrictions impaired her ability to effectively and properly perform her regular job duties. No persuasive evidence demonstrates that Claimant's pre-injury job duties were different from her post-injury job duties. Claimant contends that Employer terminated her because of her work injury; however, there was no persuasive or credible evidence to support Claimant's contention. Accordingly, Claimant's claim for TTD commencing on December 27, 2008 is denied.

ORDER

It is therefore ordered that:

1. Claimant was not responsible for termination of her employment.

2. Claimant's claim for TTD commencing on December 27, 2008 is denied.

3. All matters not determined herein are reserved for future determination.

DATED: July 17, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-605-087

ISSUES

- Did the claimant prove by a preponderance of the evidence that he is permanently and totally disabled as a result of the industrial injury of December 28, 2003?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

The claimant is 49 years of age. The claimant is a high school graduate and has an associate's degree in mold making technology.

The claimant worked for the employer as a plastics mold maker from July 1, 1991, through July 1, 2004. In this position the claimant operated computer equipment used to manufacture molds and lifted heavy materials used in the mold manufacturing process. The claimant also supervised two to four other employees.

Prior to beginning work for the employer the claimant had an employment history that included truck driving, warehouse work, automobile bodywork, and farm work. The ALJ infers that all of these jobs involved relatively heavy labor.

On December 28, 2003, the claimant sustained a low back injury arising out of and in the course of employment with the employer. The claimant bent over to obtain something from a toolbox and felt the sudden onset of low back and left leg pain.

Prior to the 2003 injury, the claimant sustained a work-related back injury in 1993. This injury resulted in low back surgery. Apparently the claimant recovered well from the surgery but experienced some intermittent symptoms. The claimant was able to continue his employment as a mold maker.

In February 2004 Dr. Timothy Wirt, M.D., performed the first surgery related to the 2003 injury. This surgery consisted of an L4-5 central intralaminar decompression, discectomy and laminectomy with bilateral L5 foraminotomy. Following this surgery theclaimant enjoyed only short-term improvement in his symptoms.

The claimant returned to work after the February 2004 surgery and continued doing his job with some modifications. The claimant was laid off in July 2004 when the employer closed the plant.

The claimant underwent a second surgery on September 2, 2004, consisting of full decompression and laminectomy at L4-5 and L5-S1 with medial facetectomy at L4-5 and right interbody fusion at L4-5 and bilateral posterolateral fusion at L4-5.

On October 10, 2005, a treating physician placed the claimant at maximum medical improvement (MMI). The claimant then underwent a Division-sponsored independent medical examination (DIME) performed by Dr. Gary Zuehlsdorff, D.O. Dr. Zuehlsdorff

opined the claimant was not at MMI and recommended further treatment. Dr. John Charbonneau, M.D., then assumed responsibility for treatment of the claimant.

Dr. Charbonneau first examined the claimant on August 29, 2006. Dr. Charbonneau noted low back tenderness on palpation and left calf atrophy. Dr. Charbonneau referred the claimant to Dr. Dan Bruns, PsyD for psychological evaluation and to Robert Benz, M.D., for a surgical consultation.

Dr. Bruns examined the claimant on September 14, 2006, for the purpose of determining whether psychological factors could be complicating the claimant's treatment. During this evaluation the claimant advised Dr. Bruns that he usually walked twice daily for 30 to 45 minutes. Dr. Bruns assessed an adjustment disorder with depressed mood and anxiety. Dr. Bruns recommended psychotherapy and the use of psychoactive medications.

After various diagnostic procedures it was determined that the claimant had a pseudoarthrosis at L4-5. Consequently, on March 8, 2007, Dr. Benz performed surgery to "redo" the L4-5 fusion, and also performed a new fusion at L5-S1.

In December 2007 the claimant had a heart attack while being arrested for DUI. The heart attack was associated with cardiomyopathy complicated by alcohol abuse. The claimant was hospitalized and a defibrillator was surgically implanted.

On January 23, 2008, Dr. Charbonneau examined the claimant and placed him at MMI for his injury-related back condition. At this examination the claimant reported "a lot of low back pain" but was not describing radiculopathy. Dr. Charbonneau determined the claimant was a poor candidate for a work-conditioning program considering his history of cardiomyopathy and recent hospitalizations. Dr. Charbonneau imposed permanent restrictions of lifting, pushing, pulling, and carrying a maximum of twenty pounds; limited bending and twisting; and change of positions as needed for comfort. Dr. Charbonneau recommended maintenance care in the form of medications, including Cymbalta, Cyclobenzaprine, Trazodone, Hydrocodone and Naproxen (both used on an as needed basis). He also ordered a six-month health club membership and eight to ten psychotherapy sessions with Dr. Bruns.

Dr. Bruns examined the claimant on April 21, 2008, after having not seen the claimant since October 22, 2007. In the April 2008 note Dr. Bruns recorded that after his session with the claimant in October 2007 the claimant began drinking heavily, was arrested for DUI, and had a heart attack during the arrest. Dr. Bruns also noted that at the October 2007 he suggested to the claimant the possibility of returning to "light duty" work. At the April 2008 session the claimant told Dr. Bruns that he considered the suggestion of light duty work to be "offensive," and that, "he had never done light duty work, and had no intention of ever doing so."

On April 21, 2008, Dr. Bruns assessed "major depression associated with severe alcoholism, currently in remission." Dr. Bruns noted the claimant was reluctant to proceed with further psychological treatment and, considering the claimant's rejection of further therapy, opined it is preferable to treat the depression with medication. Dr. Bruns

opined the claimant has reached psychological MMI since he has no desire to attend additional treatment.

Dr. Zuehlsdorff performed a follow-up DIME on June 10, 2008. The claimant advised Dr. Zuehlsdorff that he was taking various medications for his heart condition, Cymbalta for depression and pain, as well as Flexeril, Vicodin, Trazodone and Naprosyn. The claimant stated that felt 70 percent better since the last DIME with average pain of 3-4/10 while on medications. Dr. Zuehlsdorff opined the claimant was at MMI and assessed a 29 percent whole person rating for the claimant's physical impairment and 3 percent impairment for psychological problems. The combined rating was 31 percent whole person impairment. Dr. Zuehlsdorff expressed agreement with the permanent restrictions imposed by Dr. Charbonneau.

The claimant requested a "Workers' Compensation Evaluation" by O.T. Resources, Inc. The evaluation included several physical and mental tests, as well as an evaluation of the claimant's medical and vocational history. Marie Andrews, OTR met with the claimant, performed the various tests and observations, and compiled the data. Doris Shriver, occupational therapist, evaluated the test results and other data, qualified rehabilitation consultant and certified life care planner. On March 19, 2009, a report was issued and signed by Ms. Andrews and Ms. Shriver.

Prior to beginning the evaluation the claimant completed a questionnaire at the request of O.T. Resources, Inc. In response to the written questions contained in the questionnaire the claimant wrote that he could stand 10 to 30 minutes, could sit 30 to 45 minutes before he needed to lie down, and could walk two blocks. The claimant also wrote that in an 8 hour day he could stand 1.5 hours, could sit 1 hour, could walk 1.5 hours, and could lie down 4 hours

The O.T. Resources, Inc. report determines the claimant is restricted to no lifting from the floor, a one-time maximum lift of ten pounds from waist to shoulder, and a one-time maximum lift of ten pounds from waist to overhead. The report also restricts the claimant to lifting five pounds occasionally from waist to shoulder and five pounds occasionally from waist to overhead. The report concludes the claimant cannot perform any frequent or continuous lifting. These lifting restrictions are based on a "dynamic blind box test." Additionally, the O.T. Resources, Inc. report restricts the claimant from sitting more than 30 to 45 minutes at a time totaling no more than 1 hour in an 8 hour day; standing for 10 minutes at a time totaling no more than 1.5 hours per day in an 8 hour day; walking for 2 blocks totaling no more than 1.5 hours per day in an 8 hour day; and lying down limited to 4 hours per day in an 8 hour day. The report indicates the sitting and standing restrictions were based on observed performance and "timed during distracter tests." The report also restricts the claimant to using his hands no more than 45 minutes at a time totaling more than 1 hour per day in an 8-hour day.

The O.T. Resources, Inc. report concludes that the claimant is restricted to functioning at less than a sedentary level and that, considering his low motor skills and chronic pain, he cannot return to his pre-injury employment and it is unlikely that vocational rehabilitation would be successful.

The parties deposed Dr. Charbonneau on May 18, 2009. Dr. Charbonneau testified that he is board certified in occupational medicine. He further testified that he is very familiar with the protocols and interpretation of functional capacity evaluations (FCEs). This is true because he used to be in a practice that performed FCEs, and he still interprets many of them when determining fitness for duty of railroad workers. At the deposition Dr. Charbonneau reviewed the O.T. Resources, Inc. evaluation.

Dr. Charbonneau testified that he had most recently examined the claimant on February 9, 2009, and he would stand by the permanent restrictions he imposed in his report of January 23, 2008. Dr. Charbonneau opined the claimant is able to return to work and that it "would be good for him" to do so. Dr. Charbonneau opined that the claimant could perform assembly, clerical and cashier type work.

Dr. Charbonneau's opinions were not altered by the restrictions imposed in the O.T. Resources, Inc. report. Dr. Charbonneau was critical of the O.T. Resources, Inc. report, stating that he could not tell from the report what validity criteria were used to determine the reliability of the testing results. Specifically he noted the absence of comparative testing data, blood pressure monitoring, heart rate monitoring and grip strength testing. In addition Dr. Charbonneau noted the restrictions imposed by O.T. Resources, Inc. appear to be the result of limited testing in combination with the claimant's own subjective reports of symptoms. Dr. Charbonneau opined that the claimant can sit and stand longer than reflected in the O.T. Resources, Inc. report. He also opined that the limitation on hand use makes no sense.

The respondents referred the claimant to Katie Montoya for a vocational evaluation. Ms. Montoya is a vocational consultant and a rehabilitation counselor. In preparing her evaluation Ms. Montoya met with the claimant, reviewed medical documents and performed market research. In a report dated March 6, 2009, Ms. Montoya opined the claimant is capable of finding employment in several areas of the labor market. Ms Montoya stated that her opinion is predicated on the restrictions imposed by Dr. Charbonneau. Ms. Montoya attached descriptions of a number of jobs she believes the claimant is able to perform, including clerical, cashier and customer service jobs.

Doris Shriver testified at the hearing held on April 21, 2009. Ms. Shriver testified that the claimant is unable to perform any of the jobs identified by Ms. Montoya, either because they exceed the physical restrictions identified in the O.T. Resources, Inc. report, or because they require "gross motor skills" greater than those possessed by the claimant. Ms Shriver explained that under "OSHA standards" it is necessary to reduce a person's demonstrated lifting capacity by half in order to insure safety. Ms. Shriver opined that the O.T. Resources, Inc. tests were valid based on observation and distraction testing. Ms. Shriver admitted that O.T. Resources, Inc. usually conducts heart rate and blood pressure monitoring during an examination, but it did not do so during the claimant's evaluation because of an "equipment malfunction."

The claimant testified that he does not believe he is able to return to work because he is in constant pain. He stated that he experiences pain 200 to 300 times per day. He has pain in the back near the belt line, pain in his left buttock and pain down the left leg. He

stated that he lies down 3 to 4 hours per day and leads a very restricted life-style. The claimant described various modifications of furniture and cabinets that he has implemented to remain comfortable and to complete day-to-day tasks.

The claimant failed to prove it is more probably true than not that he is unable to earn wages in any employment. The ALJ is persuaded that the restrictions imposed by Dr. Charbonneau represent the claimant's actual physical limitations and capacity to perform activities. Dr. Charbonneau, who has professional expertise and knowledge in the use of FCE testing techniques, persuasively opined that the restrictions described in the O.T. Resources, Inc. report are not reliable because they do not describe the use of common validity measures and criteria, but instead appear to represent a combination of test results and the claimant's subjective reports of symptoms. In this regard the ALJ finds that Dr. Charbonneau's opinion is supported by evidence that the limitations the claimant self-reported when answering the questionnaire prior to the O.T. Resources, Inc. evaluation closely resemble the restrictions finally imposed in the completed report. Ms. Shriver also admitted that validity measures involving heart rate and blood pressure monitoring are typically performed, but were not done in this case because of a technical problem. Finally, the validity of the restrictions imposed by Dr. Charbonneau is corroborated by the opinion of the DIME physician, Dr. Zuehlsdorff. Dr. Zuehlsdorff agreed with the restrictions imposed by Dr. Charbonneau.

The ALJ also credits the opinion of Ms. Montoya that the claimant is employable in one of his available labor markets considering the restrictions imposed by Dr. Charbonneau. The ALJ is not persuaded by the contrary opinion of Ms. Shriver because it is predicated on the overly narrow restrictions imposed by O.T. Resources, Inc.

The ALJ also finds that the claimant's testimony that he can't perform any work because of his pain is not entitled to significant weight. In this regard, the ALJ notes that at the DIME performed by Dr. Zuehlsdorff on June 10, 2008, the claimant stated he was 70 percent better than at the time of the previous DIME. Further, in September 2006, the claimant told Dr. Bruns he could walk for 30 to 45 minutes twice per day. However, in the O.T. Resources, Inc. questionnaire the claimant stated he could walk only 2 blocks before he needed to rest. This report came after the claimant told Dr. Zuehlsdorff that he was 70 percent better following the fusion surgery in March 2007. Finally, the claimant told Dr. Bruns that he was "offended" by the suggestion that he might consider performing lighter work. The ALJ infers from the claimant's reaction to Dr. Bruns' suggestion that to some degree the claimant has deliberately chosen not to work because he does not care for the kinds of light-duty work that remain available to him after the industrial injury. Although the claimant may not prefer light duty or sedentary employment, that does not mean he is unable to perform it. The ALJ also finds the claimant has demonstrated the ability to develop knowledge based and interpersonal skills and apply those skills in the workplace. The claimant obtained an associate's degree, and acted as a supervisor in the employer's plastic mold business.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

1. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

PERMANENT TOTAL DISABILITY

The claimant contends the evidence establishes he is entitled to award of permanent total disability benefits. The ALJ disagrees.

To establish his claim that he is permanently and totally disabled, the claimant shoulders the burden of proving by a preponderance of the evidence that he is unable to earn any wages in the same or other employment. Sections 8-40-201(16.5)(a) and 8-43-201, C.R.S.; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The claimant must also prove the industrial injury was a significant causative factor in the PTD by demonstrating a direct causal relationship between the injury and the PTD. *Joslins Dry Goods Company v. Industrial Claim Appeals Office,* 21 P.3d 866 (Colo. App. 2001). The term "any wages" means more than zero wages. *See Lobb v. Industrial Claim Appeals Office,* 948 P.2d 115 (Colo. App. 1997); *McKinney v. Industrial Claim Appeals Office,* 894 P.2d 42 (Colo. App. 1995). In weighing whether the claimant is able to earn any wages, the ALJ may consider various human factors, including the claimant's physical condition, mental ability, age, employment history, education, and availability of work that the claimant could perform. *Weld County School Dist. Re-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). The ALJ may also consider the claimant's ability to handle pain and the perception of pain. *Darnall v. Weld County,* W.C. No. 4-164-380 (ICAO April 10, 1998).

The critical test is whether employment exists that is reasonably available to the claimant under his or her particular circumstances. *Weld County School Dist. Re-12 v. Bymer*, *supra*. The question of whether the claimant proved inability to earn wages in the same or other employment presents a question of fact for resolution by the ALJ. *Best-Way Concrete Co. v. Baumgartner,* 908 P.2d 1194 (Colo. App. 1995).

As determined in Findings of Fact 27 through 29, the ALJ concludes the claimant failed to prove it is more probably true than not that he is unable to earn wages in any employment. The ALJ finds that the claimant's actual physical restrictions are those imposed by Dr. Charbonneau. Conversely, the ALJ is not persuaded that the O.T. Resources, Inc. testing procedures were valid, or that the resulting conclusions accurately reflect the claimant's true restrictions and limitations. In reaching these conclusions the ALJ has credited the persuasive testimony and reports of Dr. Charbonneau, which are corroborated by the credible opinions of Zuehlsdorff. The testimony and reports of Ms. Montoya persuade the ALJ that, considering the restrictions imposed by Dr. Charbonneau, there are jobs available to the claimant within the available labor market. Finally the ALJ is not persuaded by the claimant's testimony that his pain and limitations are so pervasive that he is unable to work. Instead, the ALJ finds it is more probably true than not that the claimant has greater physical capacity to work than he believes. The ALJ is also persuaded that the claimant has chosen not to work because he does not like the types of light-duty jobs that are available to him within his residual physical abilities.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claim for permanent total disability benefits is denied and dismissed.

2. Issues not resolved by this order are reserved for future determination.

DATED: July 20, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-752-712

ISSUES

The sole issue determined herein is compensability. The parties stipulated that claimant's average weekly wage was $400.88.

FINDINGS OF FACT

1.Claimant has been employed as an Activity Aide by the Employer, working with Alzheimer's patients.

2.Claimant had a previous left shoulder surgery. Claimant also had suffered right shoulder pain off and on for about three years. On June 5, 2007, Dr. Pak received a history of one and a half years of right shoulder pain. He diagnosed tendonitis and arthritis. He injected the shoulder and recommended physical therapy. Claimant needed no additional treatment for her right shoulder at that time.

3.On November 12, 2007, Claimant was helping a patient to get up from a chair by boosting and lifting the patient. Claimant lifted with right arm extended and engaged in elbow flexion. She experienced a sudden sharp pain within the right shoulder joint.

4.Claimant immediately reported to Nurse Cawley, who recorded the fact that claimant reported the injury at approximately 3:30 p.m. on November 12, 2007. Claimant continued to work until about 5:00 p.m. She took Advil and went home.

5.Ms. Caywood, the Activities Director on November 13, 2007, also prepared notes that the Claimant reported the incident on November 12, 2007 and was instructed to go to an authorized provider. Claimant wanted to be treated by the surgeon for her previous left shoulder problem, Dr. Rahill. She got an appointment for November 16.

6.On November 13, 2007, claimant sought care at Memorial Urgent Care due to right shoulder pain. The facility recorded a history of no injury, although claimant had already reported to her employer the previous day that she had suffered the injury.

7.On November 15, 2007, claimant sought reexamination by Dr. Bierbrauer for treatment of a trigger finger problems. She reported that she also had right shoulder pain. The physician recorded a history of one week, but claimant reported only one day of such pain.

8.On November 16, 2007, Dr. Rahill examined claimant, who reported that her right shoulder pain had returned after the June 2007 injection. Dr. Rahill recommended a magnetic resonance image ("MRI") of the right shoulder.

9.The November 29, 2007, MRI showed a full thickness tear of the supraspinatus tendon in the right shoulder.

10.On January 10, 2008, Dr. Rahill performed surgery to repair the tendon tear.

11.On May 3, 2008, claimant filed her workers' claim for compensation.

12.On February 19, 2009, Dr. Rook performed an independent medical examination ("IME") for claimant, who reported a history of the November 12, 2007, lifting injury to her right shoulder. Dr. Rook concluded that claimant had suffered the right shoulder rotator cuff tear on November 12, 2007.

13.On April 20, 2009, Dr. Pitzer performed a medical record review for respondents. Dr. Pitzer noted that the initial medical records did not indicate a November 12, 2007, work injury.

14.On May 3, 2009, Dr. Rook disagreed with Dr. Pitzer's conclusion that he could not relate the medical treatment to a November 12, 2007, work injury.

15.Dr. Rook testified at hearing consistent with his report. He noted that the reported mechanism of injury is consistent with the diagnosis because claimant's movements would have stressed her rotator cuff. He concluded that the work activities on November 12, 2007, aggravated her preexisting impingement, requiring further medical treatment.

16.Dr. Pitzer noted that the medical records by the treating physicians did not contain a history of the November 12, 2007, accident. He concluded that claimant's symptoms were simply the result of her preexisting right shoulder problems. Dr. Pitzer agreed that claimant had bone spurs and impingement that predisposed her to rotator cuff tears.

17.Claimant has proven by a preponderance of the evidence that she suffered an accidental injury to her right shoulder arising out of and in the course of employment on November 12, 2007. Claimant clearly had preexisting right shoulder pain. She was diagnosed with tendonitis and arthritis in June 2007, but she improved with an injection. The November 12 lifting incident clearly took place as alleged. Ms. Cawley completed a report that claimant complained at 5:30 p.m. on November 12, 2007, about right arm pain. Ms. Caywood also prepared notes that claimant reported the November 12 work injury and was instructed to go to an authorized provider. The opinion of Dr. Rook is more persuasive than that of Dr. Pitzer. Claimant suffered a November 12, 2007, aggravation of her preexisting condition, resulting in the full-thickness tear of the supraspinatus. The mechanism of injury is consistent with the pathology. She reported the injury to the employer, although the initial physicians did not receive an accurate history.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of*

Boulder v. Streeb, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, claimant has proven by a preponderance of the evidence that she suffered an accidental injury to her right shoulder arising out of and in the course of employment on November 12, 2007.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers. The parties did not stipulate to any specific benefits and none were requested.

2. All matters not determined herein are reserved for future determination.

DATED: July 20, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-788-577

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable lower back injury during the course and scope of his employment with Employer on approximately June 25, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

FINDINGS OF FACT

1. Claimant is a 34 year-old male who began working for Employer as a laborer in August 2005. His job duties involved mixing cement and emptying the cement mixture into a metal mold to create concrete blocks called "car stops." The concrete blocks weighed between 120 and 180 pounds.

2. Claimant testified that while he was moving a concrete block on approximately June 25, 2008 he began to experience pain in his lower back. He explained that he reported the incident to his supervisor, Edward Connors, but was not referred for medical treatment.

3. In contrast, Mr. Connors testified that he had observed Claimant limping and having difficulty standing up straight prior to June 25, 2008. Moreover, he remarked that Claimant had been experiencing back pain since he was hired in 2005. Mr. Connors also noted that Claimant's back pain had preceded his employment with Employer. He acknowledged that Claimant mentioned back pain in June 2008. However, Mr. Connors commented that he offered Claimant medical treatment and Claimant declined because he had suffered from back pain for half his life.

4. Claimant stated that he initially believed that his lower back pain would resolve. However, because his symptoms did not improve he sought treatment with personal care provider Kaiser Permanente on June 28, 2008.

5. Claimant reported to Kaiser that he had suffered three days of gradually increasing lumbar pain "without specific trauma." He did not explain that he had injured his back while moving concrete blocks for Employer.

6. Claimant continued to receive treatment at Kaiser Permanente through March 18, 2009. He testified that after the third or fourth visit he realized that his condition was more serious than he initially thought. An MRI of his lumbar spine revealed a lumbar disc herniation. After learning of the diagnosis and course of treatment, Claimant became concerned about the costs of medical expenses for his condition.

7. Claimant testified that he always knew his back condition was work-related but was afraid to report the injury because he feared losing his job. Claimant also testified that he was not sure the injury was work-related but became convinced it was related to his employment after an "analysis" during the months following his injury.

8. On March 19, 2009 Claimant reported his lower back injury to Employer. On the same date, a total of 12 employees were laid-off from employment with Employer. Mr. Connors explained that the decision to lay-off multiple workers occurred for economic reasons prior to March 19, 2009.

9. Employer subsequently referred Claimant to Concentra Medical Centers for treatment. On April 13, 2009 Claimant visited John Burris, M.D. for an evaluation. Dr. Burris observed multiple inconsistencies in Claimant's pain behaviors and deferred a causality determination until he obtained records from Kaiser Permanente and Employer. He noted that "[d]ue to the number of inconsistencies, I am not going to assign any work restrictions."

10. Dr. Burris testified at the hearing in this matter. He persuasively concluded that Claimant's lower back condition was not caused by his employment with Employer. Dr. Burris explained that after receiving the Kaiser Permanente records he noticed marked inconsistencies with regard to Claimant's report of his injury. He also noted additional discrepancies with respect to Claimant's hearing testimony and the history documented in the records. Dr. Burris considered Claimant's specific report to Kaiser on June 28, 2008 that he suffered from three days of gradually increasing lumbar pain without specific trauma. Significantly, Dr. Burris also noted that during Claimant's April 6, 2009 Kaiser evaluation he stated that the onset of his symptoms occurred approximately six months earlier. Dr. Burris also testified that Claimant reported to him that he only decided to pursue benefits through the workers' compensation system after Kaiser advised him that treatment could be expensive and it would be better to proceed through the workers' compensation system.

11. Claimant has failed to demonstrate that it is more probably true than not that he suffered a compensable lower back injury during the course and scope of his employment with Employer on approximately June 25, 2008. His employment activities on June 25, 2008 did not aggravate, accelerate, or combine with any pre-existing back problems to produce a need for medical treatment. Claimant's testimony is internally inconsistent and conflicts with the medical evidence. Claimant asserted that he experienced lower back pain on approximately June 25, 2008 while moving a concrete block. Claimant explained that he always knew his back condition was work-related but was afraid to report the injury because he feared losing his job. However, Claimant also testified that he was not sure the injury was work-related but became convinced it was related to his employment after an "analysis" during the months following his injury. Moreover, on June 28, 2008 Claimant visited personal insurer Kaiser Permanente and reported three days of gradually increasing lumbar pain "without specific trauma." Claimant did not ultimately report the June 25, 2008 incident to Employer and seek medical treatment until March 19, 2009.

12. The credible testimony of other witnesses also contradicts Claimant's account. Mr. Connors remarked that Claimant had experienced back pain since he began employment in 2005 and that Claimant's back pain had preceded his employment with Employer. Dr. Burris persuasively concluded that Claimant's lower back condition was not caused by his employment for Employer. Dr. Burris noted several inconsistencies between Claimant's testimony and Kaiser's medical records. Dr. Burris also testified that Claimant reported to him that he only decided to pursue benefits through the workers' compensation system after Kaiser advised him that treatment could be expensive and it would be better to proceed through the workers' compensation system.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P. 3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he suffered a compensable lower back injury during the course and scope of his employment with Employer on approximately June 25, 2008. His employment activities on June 25, 2008 did not aggravate, accelerate, or combine with any pre-existing back problems to produce a need for medical treatment. Claimant's testimony is internally inconsistent and conflicts with the medical evidence. Claimant asserted that he experienced lower back pain on approximately June 25, 2008 while moving a concrete block. Claimant explained that he always knew his back condition was work-related but was afraid to report the injury because he feared losing his job. However, Claimant also testified that he was not sure the injury was work-related but became convinced it was related to his employment after an "analysis" during the months following his injury. Moreover, on June 28, 2008 Claimant visited personal insurer Kaiser Permanente and reported three days of gradually increasing lumbar pain "without specific trauma." Claimant did not ultimately report the June 25, 2008 incident to Employer and seek medical treatment until March 19, 2009.

7. The credible testimony of other witnesses also contradicts Claimant's account. Mr. Connors remarked that Claimant had experienced back pain since he began employment in 2005 and that Claimant's back pain had preceded his employment with Employer. Dr. Burris persuasively concluded that Claimant's lower back condition was not caused by his employment for Employer. Dr. Burris noted several inconsistencies between Claimant's testimony and Kaiser's medical records. Dr. Burris also testified that Claimant reported to him that he only decided to pursue benefits through the workers' compensation system after Kaiser advised him that treatment could be expensive and it would be better to proceed through the workers' compensation system.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Workers' Compensation benefits is denied and dismissed.

DATED: July 20, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-776-684

ISSUES

1. Did workers' compensation insurance coverage exist as to Claimant given Claimant, as president and owner of CMR Siding, Inc., on May 8, 2007, rejected workers' compensation coverage for himself pursuant to Section 8-41-202, C.R.S.?

2. Did Claimant prove by a preponderance of the evidence that he sustained a compensable injury that arose out of the course and scope of his employment with Employer on September 11, 2008?

3. If Claimant establishes coverage and a compensable claim, then Insurer is liable for payment of the September 11, 2008, medical bill from Dr. Sally Parsons, in amounts not to exceed the Colorado Medical Fee Schedule.

FINDINGS OF FACT

1. Bunn is employed as the managing insurance agent at First Main Street Insurance. First Main Street Insurance is an insurance broker for multiple insurance companies, and agent for its policy holders. Claimant is the president and owner of Employer. He incorporated Employer in 2005 with the Colorado Secretary of State. Claimant's address is 3530 Willow Rd., the same address as Employer.

2. On May 8, 2007, Claimant went into First Main Street Insurance to obtain workers' compensation insurance quotes. He met with Bunn. He did not request an interpreter. Bunn spoke English to Claimant. She did not have a difficult time understanding Claimant. Mathews, another employee of First Main Street Insurance, also spoke to Claimant in English.

3. Bunn provided multiple workers' compensation quotes to Claimant. She gave Claimant a quote for coverage for himself and for Employer's employees. That quote was for around $6,000.00. Bunn also gave a quote for coverage for just an employee, excluding Claimant, as the officer and president of Employer. That quote was substantially lower.

4. After providing quotes to Claimant, Claimant left First Main Street Insurance to consider the quotes. Later that same day, Claimant returned to First Main Street Insurance and met with Bunn. Claimant expressed interest in the quote that excluded himself from coverage as the president and owner of Employer. Claimant chose to waive coverage for himself.

5. Claimant provided corporate information for Employer to Bunn. Bunn placed an "X" on policy documents where Claimant was to sign his name. As a service to her customers, Bunn fills in parts of documents for the customers.

6. Bunn sat at her desk with Claimant and went over the policy documents and waiver of coverage form with Claimant. Bunn did not read the policy documents to

Claimant, but Claimant went through the policy documents. On the "Rejection of Coverage by Corporate Officers, Part B" form, Claimant marked the line that indicated, "hereby elect to reject workers' compensation insurance coverage based upon C.R.S. 8-41-202 (Non-agricultural)."

7. The rejection of coverage form was a previous form issued by the Division of Workers' Compensation, not the most recent published form. The form was a document previously approved by the Division.

8. Claimant's signature is on the "Rejection of Coverage by Corporate Officers, Part B" form. The rejection of coverage form is notarized; however, Claimant did not sign the rejection of coverage form in front of a notary. The waiver Claimant signed was in substantial compliance with the requirements of Section 8-41-202, C.R.S.

9. Bunn sent policy documents, including the waiver of coverage form, to Insurer. The waiver of coverage form was not sent certified to Insurer. The waiver of coverage form was received by Insurer.

10. Claimant waived coverage for himself as the officer and president of Employer. The waiver was effective and continues until Claimant sends written notice to Insurer.

11. Bunn prepared Certificates of Insurance for Employer and sent the Certificates to job sites on behalf of Claimant. Bunn did not send copies of the Certificates of Insurance to Insurer. Insurer did not receive copies of the Certificates of Insurance.

12. Claimant received a "Policy Information Page" from Insurer that indicated the policy included the endorsement "337 Excludes from Coverage." The premium for the policy was $2,140.00. Claimant received policy premium invoices sent to him and paid them.

13. The insurance policy came up for renewal in the spring of 2008. Claimant told Bunn that his work was decreasing and there would no longer be anyone but him working for Employer. Neither Claimant nor Bunn informed Insurer that Employer no longer had employees. The policy was renewed.

14. Insurer sent correspondence to Employer at 3530 Willow Rd. at the time of renewal requesting payroll records. Claimant and Employer did not send the requested documents to Insurer.

15. Insurer initiated an audit of the policy. Employer did not provide payroll records and requested information upon renewal of the policy. Therefore, Insurer utilized estimated payroll figures to compute policy premiums. Insurer did not use Claimant's wages when computing the policy premium.

16. The premium for the renewal policy was $1,950.00. Claimant continued to make premium payments after the policy renewed. The premium payments Claimant made were for the policy that excluded coverage for Claimant.

17. Insurer sent a “Policy Information Page” to Claimant that did not include the endorsement “337 Exclude from Coverage.” It is Insurer’s policy to only note such endorsement when an owner or officer is initially excluded. In this case, Insurer noted the endorsement on the initial policy documents. Insurer sent correspondence to Employer regarding “Rejected Corporate Officer From Coverage.”

18. Claimant testified that because he told Bunn that he had no other employees and that the renewal policy did not have the endorsement “337 Exclude from Coverage”, he thought he was covered under the policy. However, Claimant knew or should have known that he was not covered under the policy as the premium was not higher than it had been the year before.

19. Insurer never received written notification from Claimant revoking the waiver and rejection of coverage.

20. Claimant was not led to believe that he was covered under the policy. Claimant did not pay the extra money in premiums to cover him under the policy. When the policy renewed, Claimant paid less money for the policy than the prior year. Claimant did not notify Insurer in writing that he revoked his election to waive coverage.

21. Claimant is not credible when he testified he did not receive documents from Insurer. Policy documents, including the endorsement page titled “Rejected Corporate Officer from Coverage” were sent to 3530 Willow Rd. This is Claimant’s address. This is also the mailing address for Employer. Insurer also sent policy documents to 3530 Willow Rd. The documents sent were not returned to Insurer. Claimant received premium invoices and the policy documents.

22. Claimant was injured in an accident on September 11, 2008. The accident occurred within the course and scope of his employment. Claimant received medical treatment with the Poudre Valley Health System on September 11, 2008, for the injuries he sustained.

23. Claimant did not have workers’ compensation coverage on the date of the accident.

CONCLUSIONS OF LAW

1. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

2. The facts in a workers’ compensation case must be interpreted neutrally, neither in favor of the rights of the claimant, nor in favor of the rights of

respondents. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony in action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See*, *Prudential Ins. Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. The Judge's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the Judge has not addressed every piece of evidence or every inference that might lead to conflicting conclusions, and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo.App. 2000).

5. An insurer has the burden of establishing that a claimant waived coverage as an owner or corporate officer. Once waived, the claimant has the burden to show that he withdrew the election to waive coverage and property communicated that to the insurer

6. Section 8-41-202(1), C.R.S., provides "….a corporate officer of a corporation or a member of a limited liability company may elect to reject the provisions of articles 40 to 47 of this title." See *Anderson v. A&M Site Services*, Inc., W.C. No. 4-272-301 (ICAO, November 27, 1996) and *Lichter v. Fly Me To The Moon*, W.C. No. 4-439-165 (ICAO, December 6, 2002). ICAO, in *Anderson v. A&M Site Services*, Inc., *supra,* has recognize that even though the claimant did not intend to completely exempt himself from coverage, the election to reject coverage was binding and operated as a complete exclusion from the provisions of the Act. ICAO cited *Can-Usa Construction, Inc. v. Gerber*, 767, P.2d 765 (Colo.App. 1988), *rev'd on other grounds at* 783 P.2d 269 (1989).

7. Section 8-41-202(2), C.R.S., provides "[a] corporate officer's or member's election to reject the provisions of articles 40 to 47 of this title shall continue in effect so long as the corporation's or company's insurance policy is in effect or until said officer or member, by written notice to the insurer, revokes the election to reject said provisions." Corporate officer includes "….president…"

8. Claimant has established by a preponderance of the evidence that he sustained an injury in the course and scope of his employment. Insurer has established by a preponderance of the evidence that Claimant waived coverage from Insurer. Claimant has not established by a preponderance of the evidence that he revoked the waiver of coverage in writing. Claimant was not covered at the time of the accident. Insurer is not liable for benefits in this claim.

ORDER

It is therefore ordered that Insurer is not liable for benefits in this claim.

DATED: *July 21, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-326-355

ISSUES

Claimant's issues for hearing included:

1. Disfigurement.

2. Permanent partial disability benefits. (Claimant withdrew the issue of permanent partial disability at hearing).

3. Whether or not Claimant is entitled to temporary total or temporary partial disability benefits from date of injury to February 28, 2000. (Claimant withdrew the issue of temporary total and temporary partial disability at hearing).

4. Constitutional challenge to the ripeness statute.

Respondents included the following issues:

5. Issue preclusion and fact preclusion based on Administrative Law Judge Margot Jones's Order that previously resolved the temporary total disability/temporary partial disability issue. (Respondents withdrew this issue after Claimant withdrew his request for temporary total or temporary partial disability benefits from date of injury to February 28, 2000).

6. Lack of ripeness of temporary total disability/temporary partial disability issues entitles Respondents to attorney fees and costs §8-43-211.

7. Claimant must overcome Division sponsored independent medical examination by clear and convincing evidence §8-42-107. (Respondents withdrew this issue after Claimant withdrew his request for permanent partial disability benefits).

8. Permanent partial disability benefits: Respondents want to uphold the Division IME conclusions that Claimant's permanent impairment is not related to the work injury.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge makes the following Findings of Fact:

1. On January 30, 1997 Claimant sustained a work related injury to his back while employed as a welder by Employer.

2. Claimant treated with the authorized medical provider, Dr. Kirk Holmboe, at Concentra. Dr. Holmboe concluded that Clamant reached maximum medical improvement of his work related injury on February 20, 1997, and released Claimant without any impairment due to the work injury and reported Claimant did not require further treatment.

3. Claimant did not miss any time from work as a result of the original injury and continued to perform his job until he voluntarily terminated on January 29, 1998, one year from the original date of loss.

4. Clamant started work for D & D Metal Products. Claimant worked at D&D for approximately two years. He terminated February 28, 2000, for health reasons; he felt he could not perform his job.

5. The parties proceeded to hearing before Judge Margot Jones on the issue of temporary disability benefits. In Conclusions of Law paragraph 5 and Order paragraph 3 of Judge Jones's October 18, 2004 Order on Remand, Judge Jones concluded that "Claimant became disabled from his usual work on February 28, 2000, and on going…" and is entitled to TTD commencing on February 28, 2000.

6. Dr. J. Scott Bainbridge became the agreed upon authorized medical provider for Claimant's care and treatment of his work injury.

7. Dr. Bainbridge reported January 23, 2003:

> DISCUSSION OF CAUSATION: I have reviewed the medical records very carefully and conscientiously and have taken into consideration [Claimant's] view of the history as well. It is my opinion that [Claimant] sustained a thoracic strain injury on January 29, 1997, and that this did in fact come to resolution without permanent impairment. It is clear that he had at least three other incidences where he had significant aggravations of his pain, on September 22, 1997, in May of 1998, and in the latter portion of 1999. It is clear from the record that the right upper extremity symptoms did not occur until approximately November or December of 1999. I would thus state that Douglas's cervical radiculitis and /or facet syndrome is a result of either his employment at D and D Metals or occurred at home. If ulnar neuropathy at the right elbow is diagnosed, then this would be unrelated to the cervical problems and not tied to any specific work incident.

Dr. Bainbridge reported that Claimant reached MMI on April 13, 2006 and rated Claimant with 20% whole person impairment.

8. Claimant requested a Division IME that was performed by Dr. Linda Mitchell. On October 29, 2008, Dr. Mitchell performed the Division IME. She agreed with Dr. Bainbridge that Claimant reached MMI as of April 13, 2006. She rated Claimant with a 15% whole person impairment, however, concluded that Claimant's:

> … cervical spondylosis, facet syndrome, and myofascial pain are chronic, progressive, degenerative conditions that are unrelated to the work injury. I would agree with Dr. Bainbridge that [Claimant's] thoracic strain of 01/27/97 resolved, and the cervical condition and myofascial pain are either due to another injury either at home or other place of employment. I would add that they might simply be progressive, degenerative conditions that are not related to any specific injury. Medical literature that has been published in recent years supports the concept that degenerative spinal conditions have a significant genetic component and are not related to occupation. That being said, I would not consider the medical treatment subsequent to 02/20/97 to be medically reasonable and necessary for the thoracic strain of 01/29/97, although the treatment would be reasonable and necessary for the cervical condition and myofascial pain.

9. Dr. Mitchell recognized that relatedness issues apparently went to hearing but if causality were not settled then impairment for the February 29, 1997, thoracic strain would be 0% whole person.

10. Respondents prepared a Final Admission of Liability December 5, 2008, and admitted for a 15% whole person impairment, however, remarked that "DIME Dr. Mitchell report of 11-28-08, attached, did not relate any permanent impairment to the work injury, however, ALJ Jones previously found ongoing problems work related. Dr Mitchell rated Claimant with 15% whole person if ongoing problems determined related. Respondents reserve the right to challenge relatedness of permanent impairment if Claimant objects to this admission."

11. On January 2, 2009, Claimant's attorney filed an Application for Hearing and included the issues of temporary total and temporary partial disability benefits from the date of injury to February 28, 2000.

12. On January 19, 2009, Respondents sent Claimant's counsel a letter and notified him that the issues of temporary total and temporary partial disability were previously litigated before Judge Jones and that if he did not withdraw the issues, Respondents intended to list the issue of ripeness and request attorney fees and costs.

13. On January 29, 2009, Respondents filed a Response to Application for Hearing and included the issues of ripeness of Claimant's temporary disability request and permanent partial disability benefits.

14. At the April 22, 2009 hearing, Claimant's attorney withdrew the issues of temporary total and temporary partial disability benefits from dated of injury to February 28, 2000.

15. Respondents are entitled to attorney's fees and costs incurred for the preparation to defend the issues of temporary total and temporary partial disability benefits. Respondents' attorney, David Dworkin, submitted an affidavit setting forth the attorney's fees incurred in the amount of $1,261.67 and costs incurred in the amount of $44.17. Claimant's attorney did not file an objection. Therefore, Claimant's attorney, Chris Ingold, shall pay the total sum of $1,305.84 to David Dworkin for the attorney's fees and costs incurred for the preparation to defend the temporary disability issues that were not ripe at the time of filing the application for hearing.

16. As a result of his work related injury, Claimant incurred disfigurement as follows: one and one-half inch surgical scar on the front of Claimant's neck that is purple in color and a one and one-half inch surgical scar on his left hip. The disfigurement is serious, permanent, and normally exposed to public view, and entitles Claimant to a disfigurement award of $1,000.00 pursuant to §8-42-108, C.R.S.

CONCLUSIONS OF LAW

1. C.R.S. §8-42-107(8) provides that the findings of a Division sponsored independent medical evaluator selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's findings must present evidence showing it highly probable that the DIME physician is incorrect. Metro Moving & Storage Company v. Gussert, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all of the evidence, the trier of fact finds it to be highly probable and free from serious or substantial doubt. Metro Moving & Storage Company v. Gussert, supra. A mere difference of opinion between physicians fails to constitute error. See Gonzales v. Browning Ferris Industry of Colorado, W.C. No. 4-350-36 (ICAO March 22, 2000).

2. The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. Qual Med v. Industrial Claims Appeal Office, 961 P.2d 590 (Colo. App. 1998). Since the DIME physician is required to identify and evaluate all losses and restrictions which result from the industrial injury as part of the diagnostic assessment process, the DIME physician's opinion regarding causation of those losses and restrictions is subject to the same enhanced burden of proof. Qual Med v. Industrial Claims Appeal Office, supra.

3. The Division IME, Dr. Mitchell, was asked to render an opinion on permanent impairment in this matter and was not required to determine the legal effect of

the prior Judge's ruling that addressed causation of medical benefits and temporary disability benefits. In this case, Dr. Mitchell opined:

> I have been asked to comment on causality. Based on the records provided, [Claimant's] cervical spondylosis, facet syndrome, and myofascial pain are chronic, progressive, degenerative conditions that are unrelated to the injury of 01/27/97.

4. Dr. Mitchell's conclusions are supported by Dr. Holmboe, Claimant's initial authorized provider. Dr Holmboe concluded that Clamant reached MMI of his work related injury on February 20, 1997, and released Claimant without any impairment due to the work injury and reported Claimant did not require further treatment.

5. Dr. Mitchell's conclusions are supported by Dr. Bainbridge, Claimant's subsequent authorized provider. Dr. Bainbridge reported:

> DISCUSSION OF CAUSATION: I have reviewed the medical records very carefully and conscientiously and have taken into consideration [Claimant's] view of the history as well. It is my opinion that [Claimant] sustained a thoracic strain injury on January 29, 1997, and that this did in fact come to resolution without permanent impairment. It is clear that he had at least three other incidences where he had significant aggravations of his pain, on September 22, 1997, in May of 1998, and in the latter portion of 1999. It is clear from the record that the right upper extremity symptoms did not occur until approximately November or December of 1999. I would thus state that Douglas's cervical radiculitis and /or facet syndrome is a result of either his employment at D and D Metals or occurred at home. If ulnar neuropathy at the right elbow is diagnosed, then this would be unrelated to the cervical problems and not tied to any specific work incident.

6. Dr. Mitchell explained that it was her understanding that the case had gone to hearing at least twice and assuming that causality had been resolved in favor of Claimant, then she opined that Claimant sustained 15% permanent medical impairment. However, she further opined that if causality had not been resolved, then Claimant sustained 0% whole person impairment. It is concluded that Dr. Mitchell's opinion is that Claimant sustained 0% permanent medical impairment as a result of his January 27, 1997, industrial injury. This opinion has not been overcome by clear and convincing evidence. Therefore, Claimant has 0% permanent disability as a result of his industrial injury.

7. Claimant argues that the Judge does not have jurisdiction to decide this issue because: 1) that issue is closed by the filing of the Final Admission of Liability and no petition to reopen was filed; and 2) that issue was previously decided by Judge Jones. The Judge rejects both arguments. Respondents filed a Final Admission of Liability on December 5, 2008. Claimant objected to the admission of permanent partial disability benefits and filed an Application for Hearing listing permanent partial disability as an issue for determination. Respondents also listed permanent partial disability on the

Response to Application for Hearing. Therefore, the issue of permanent partial disability is ripe for adjudication.

8. Furthermore, Judge Jones' order from 2004 does not preclude a new determination of relatedness as to permanent partial disability benefits. Her Order only addressed causation as it related to medical benefits and temporary disability benefits.

9. Permanent disfigurement of parts of the body normally exposed to public view may allow for additional compensation not to exceed $2,000.00. C.R.S. §8-42-108. The Judge finds and concludes that as a result of the work related injury, Claimant incurred a disfigurement as follows: one and one-half inch surgical scar on the front of Claimant's neck that is purple in color and a one and one-half inch surgical scar on his left hip. The disfigurement is serious, permanent, and normally exposed to public view, and entitles Claimant to a disfigurement award of $1,000.00 pursuant to §8-42-108, C.R.S.

10. At hearing, Claimant's attorney withdrew the issues of temporary total disability benefits and temporary partial disability benefits from date of injury to February 28, 2000. Respondents requested attorney's fees and costs pursuant to §8-43-211(2)(d), C.R.S., for listing issues that were not ripe for adjudication at the time such request was made. Section 8-43-211(2)(d), C.R.S. requires an assessment of attorney fees and costs if a person requests or sets a hearing on any issue that is not ripe for adjudication. BCW Enterprises, Ltd. v. Industrial Claim Appeals Office, 964 P.2d 533 (Colo. App. 1997).

11. In this case, Respondents are entitled to an award of attorney fees and costs because Claimant's attorney filed an Application for Hearing that included issues of temporary total and temporary partial disability benefits from date of injury to February 28, 2000. At the time of filing, those issues were not ripe; were not real, immediate, and/ or fit for adjudication.

12. Specifically, those issues were previously litigated before Judge Jones who concluded that "Claimant became disabled from his usual work on February 28, 2000…" and is entitled to temporary total disability commencing on February 28, 2000. She based her Order on the findings that Claimant injured his back at work on January 30, 1997, however, he continued regular work, without lost time, until he terminated February 28, 2000. Judge Jones' order was final in 2004. Those issues were not ripe when Claimant's attorney included them in his January 2, 2009, Application for Hearing because the legal principles of collateral estoppel or issue preclusion, and fact preclusion or the law of the case, prevent re-litigation of the same issue.

13. Collateral estoppel, or issue preclusion, is a judicially created, equitable doctrine that operates to bar re-litigation of an issue that has been finally decided by a court in a prior action. Bebo Constr. Co v. Mattox & O'Brien, P.C., 990 P.2d 78, 84 (Colo. 1999). The doctrine serves to relieve parties of multiple lawsuits, conserve judicial resources, and promote reliance on the judicial system by preventing inconsistent decisions. Bebo Constr. Co v. Mattox & O'Brien, P.C., supra. Although originally

developed in the context of judicial proceedings, issue preclusion is just as viable in administrative proceedings and may bind parties to an administrative agency's findings of fact or conclusions of law. Id. at 85; Indus. Comm'n v. Moffat County Sch. Dist. RE No. 1, 732 P.2d 616, 620 (Colo. 1987). Issue preclusion applies to this case because: 1) the issue sought to be precluded is identical to an issue actually determined in a prior proceeding (TTD/TPD); 2) the party against whom estoppel is asserted has been party to the proceeding (same Claimant and same Claimant's counsel); 3) there is a final judgment on the merits in the prior proceeding (the 2004 Order from Judge Jones); and 4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. Bebo Constr. Co v. Mattox & O'Brien, P.C., 990 P.2d 78, 85 (Colo. 1999); Indus. Comm'n v. Moffat County Sch. Dist. RE No. 1, 732 P.2d 616, 619-620 (Colo. 1987); Sunny Acres Villa, Inc. v. Cooper, 25 P.3d 44 (Colo. 2001).

14. Respondents notified Claimant's attorney of the ripeness issue by letter dated January 19, 2009, and again in their Response to Application for Hearing dated January 29, 2009. Claimant's attorney failed to withdraw the issues until the day of hearing which necessitated Respondents prepare for those issues and incur attorney fees and costs.

ORDER

It is therefore ordered that:

1. The Division sponsored independent medical examiner, Dr. Linda Mitchell, opined that Claimant sustained 0% permanent medical impairment as a result of his January 27, 1997, industrial injury. This opinion has not been overcome by clear and convincing evidence. Therefore, Claimant has 0% permanent disability as a result of his industrial injury.

2. Respondent-Insurer shall pay to Claimant $1000.00, in a lump sum, for disfigurement. Respondent-Insurer shall be given credit for any award for disfigurement already paid to Claimant.

3. Claimant's attorney, Chris Ingold, shall pay the total sum of $1,305.84 to David Dworkin for the attorney's fees and costs incurred for the preparation to defend the temporary disability issues that were not ripe at the time of filing the application for hearing.

4. Claimant raised the issue of a Constitutional challenge to the ripeness statute. The Judge does not have jurisdiction to decide this issue.

DATED: July 21, 2009

Barbara S. Henk

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-764-408

ISSUES

The issue for determination is permanent partial disability (PPD) benefits. Respondents seek to overcome the opinion of the Division independent medical examiner (DIME).

FINDINGS OF FACT

1. On June 25, 2008, in the course and scope of her employment, Claimant was lifting a resident into the shower by pivoting with the resident when Claimant twisted her lower back. Claimant presented to Midtown Occupational Medicine where she came under the care of Heather Schmidt, MS, PA-C and Lawrence Cedillo, D.O. Claimant reported to P.A. Schmidt that she was in a squatted position and pivoting to the right when Claimant felt a pop in the right low back. P.A. Schmidt diagnosed a lumbar strain, prescribed medications, directed Claimant to physical therapy, and returned Claimant to work with restrictions.

2. On July 23, 2008, an MRI of the lumbar spine was completed at Denver Integrated Imaging North and interpreted by Samuel Ahn, M.D. It was noted that at L4-5 and L5-S1, there was mild diffuse disc bulges with mild loss of disc space height and disc desiccation. There was no central canal, lateral recess or neural foraminal stenosis. Facet joints and ligamentum flavum appeared within normal limits. The final impression was mild diffuse disc bulges at L4-5 and L5-S1. No neural impingement was noted and no other abnormalities were seen.

3. Due to lack of progress, Claimant was referred to Lawrence Lesnak, D.O. for an initial evaluation on July 23, 2008. Dr. Lesnak felt that Claimant's symptoms suggested right SI joint dysfunction. Dr. Lesnak performed an SI joint injection on August 6, 2008, that provided excellent relief for 3-4 days then symptoms subjectively worsened.

4. On August 13, 2008, Dr. Lesnak performed an EMG of the right lower extremity that was normal.

5. In late August 2008, Claimant quit her job with Employer and began working elsewhere.

6. On September 11, 2008, Claimant presented to Dr. Lesnak reporting that she had "improved dramatically." Claimant stated that she had some intermittent very

mild low back discomfort primarily at nighttime. Otherwise, Claimant had no symptoms at that point. Dr. Lesnak recommended no further diagnostic testing or interventional treatments, and opined that Claimant had attained maximum medical improvement (MMI). He found no evidence that Claimant had sustained any permanent functional impairment and he assigned no work restrictions. He concluded that it was reasonable for Claimant to utilize occasional medications anticipating that those medications would be discontinued approximately two to three months post-MMI.

7. Claimant also presented to P.A. Schmidt on September 11, 2008, for a closing evaluation. P.A. Schmidt noted that Claimant was working full duty in a "no lifting facility" and that Claimant had been tolerating that work with no problems or complications. P.A. Schmidt had spoken with Dr. Lesnak concerning his recommendations of MMI and three months of maintenance medications as well as four to six sessions of osteopathic manipulative therapy with Dr. Vavreck as post-MMI maintenance care. P.A. Schmidt concluded that Claimant could return to work full duty as of September 11, 2008, with no restrictions. She also stated that Claimant had attained MMI with no permanent impairment. Dr. Lesnak and Dr. Cedillo agreed with the assessment and plan.

8. On October 16, 2008, Dr. Lesnak examined Claimant and noted that Claimant continued to have some residual right buttock pain as well as intermittent symptoms radiating into her right posterior thigh. Claimant continued working full duty. On exam, the Claimant showed no signs of antalgic gait. She was able to perform a full squat with rise without difficulty. Lumbar spine range of motion was performed and revealed approximately 90-100 degrees of forward flexion at the waist with mild to moderate right-sided low back/superior buttock pain reproduction. Otherwise, the examination remained unchanged. Dr. Lesnak concluded that Claimant remained at MMI and he found no evidence that Claimant had sustained any permanent functional impairment as a result of the occupational injury. He did not recommend any permanent work restrictions.

9. On October 20, 2008, Respondents filed a Final Admission of Liability consistent with P.A. Schmidt's and Dr. Lesnak's September 11, 2008, assessments.

10. On November 24, 2008, Thomas W. Vavrek, D.O., completed a follow-up medical evaluation report in which he noted that Claimant had "multiple complaints… unchanged since onset of treatment which began on 9/23/08…No new complaints on exam today." As of that date, Claimant had completed six out of six visits with no subjective change in pain complaints. Claimant had been non-compliant with therapeutic activities.

11. On January 15, 2009, Claimant presented to Christopher Ryan, M.D., for an independent medical examination. Dr. Ryan diagnosed Claimant with chronic post-traumatic myofascial lumbo-pelvic pain, worsened functionally following discharge and having been placed at MMI. He noted that Claimant's functional status had deteriorated and that Claimant was no longer at MMI. He assigned a 23% whole person permanent

impairment rating, but noted that the rating would likely improve with some manual therapy. Dr. Ryan assigned a 5% impairment rating, plus range of motion limitations of 19%. Straight leg raising showed 21 degrees right and 37 degrees left. He also noted that technically Dr. Lesnak was correct in that Claimant had no specific disorder rating at the time of MMI because less than 6 months had elapsed after the injury. Dr. Ryan opined that Claimant now was entitled to a Table 53 rating for a specific disorder of the lumbar spine. He recommended that Claimant undergo further treatment similar to that which she completed under the direction of Dr. Lesnak and Dr. Vavreck.

12. On January 27, 2009, Cliff Gronseth, M.D., completed a DIME. Claimant reported constant 6/10 intensity aching pain across the right side of her low back, radiating along the sacrum into the medial aspect of the right thigh and over to the lateral aspect of the right leg and back again into the medial right foot. She stated that the "pain is about the same since this first happened." She reported occasional numbness and burning sensation on the dorsum of her right foot.

13. In his examination during the DIME, Dr. Gronseth noted moderate pain behaviors, including slow guarded movements, exclamation of pain and clutching the back at times. He noted inconsistency between supine versus seated straight leg raise and tendency for slight giveaway weakness during the right lower extremity strength testing. Claimant had an overall 3/5 Waddell's signs. Lumbar spine range of motion was painful in all directions. The measurements were considered internally valid, but the effort was of marginal credibility. The impression was that of lumbosacral sprain/strain injury with possible right sacroiliac joint disorder. Dr. Gronseth queried symptom magnification/functional overlay.

14. In the Discussion section of his DIME report, Dr. Gronseth noted that Claimant demonstrated "significant movement restrictions and voluntary guarding" on exam. Again he noted 3/5 positive Waddell's signs and moderate pain behaviors. He specifically stated that, "It is difficult to discern fact from fiction in this claim. Her straight leg test today on the right was limited to 4 degrees, while 12 days prior it was up to 20 degrees." Dr. Gronseth stated that, "The inconsistencies on today's presentation compared to the prior notes are significant. She does not demonstrate any clear objective radiculopathy type picture from the lumbar disc degeneration seen on MRI." Finally, Dr. Gronseth documented that, "She reports to me that this is her current average daily pain level and yet her mannerisms are almost incompatible with functional living."

15. Dr. Gronseth concluded that Claimant did not need surgery, but might benefit from additional maintenance care including osteopathic manipulation and possible further injections. Claimant could also take oral pain medications for the next year along with osteopathic manipulation. Finally, Dr. Gronseth considered Claimant to be at maximum medical improvement as of November 24, 2008, the last date of follow up with Dr. Vavreck. Dr. Gronseth assigned a total 16% whole person permanent impairment for the lumbar spine (5% per Table 53 of the *AMA Guides*, and 12% for limited range of motion per Tables 60 and 61 of the *AMA Guides*).

16. On April 17, 2009, ATP Lawrence Cedillo, D.O. performed a one-time follow-up evaluation. He documented that Claimant's history was inconsistent and confused, and Claimant and her husband were very frustrated and argumentative when Dr. Cedillo would not prescribe additional pain medications without further liver and kidney testing. On physical exam, Claimant's range of motion testing was "inconsistent and invalid" compared to those taken by Dr. Lesnak and Dr. Gronseth. Dr. Cedillo stated, "In light of the significant inconsistencies, pain behaviors, and symptom magnification, and considering the DIME report…who documents same…I am recommending a re-evaluation with Dr. Lesnak."

17. On April 20, 2009, Dr. Lesnak re-evaluated the Claimant for the first time following the DIME. Claimant reported that her symptoms had not changed since Dr. Lesnak's prior exam, and that she was currently working on a full-time basis without restrictions. Again, Claimant had no signs of an antalgic gait. On exam, Claimant "exhibited several pain behaviors during today's evaluation and exhibited 3/5 Waddell's signs." Dr. Lesnak reviewed the DIME report wherein Claimant had "exhibited numerous pain behaviors and nonphysiologic findings and her effort was submaximal during range of motion testing." He stated that, "According to the *AMA Guides*, when range of motion is limited by pain, fear of pain or neuromuscular inhibition, or poor/submaximal effort, range of motion measurements cannot be utilized for the purposes of calculating an impairment rating." (emphasis in the original).

18. Dr. Lesnak completed a follow-up evaluation on May 20, 2009. Claimant reported no changes in symptoms, and she continued to exhibit several pain behaviors and nonphysiologic findings, including 3-4/5 positive Waddell signs.

19. On May 22, 2009, Dr. Cedillo performed a post-MMI maintenance evaluation and stated in his report, "I do agreed with Dr. Lesnak's impairment rating and I agree with his opinion of his review of the DIME rating in regards to this case." He further agreed with Dr. Lesnak's recommendations for maintenance care and discharged Claimant to Dr. Lesnak's care.

20. Dr. Lesnak, a treating physician, is an expert in physical medicine and rehabilitation. Dr. Lesnak is board certified and Level II accredited with the Division of Workers' Compensation.

21. Dr. Lesnak noted during his physical examination of Claimant on September 11, 2008, that Claimant's condition had virtually resolved with Claimant reporting dramatic improvement and only mild low back discomfort. The exam and Claimant's reports of pain were inconsistent with Claimant's presentation prior to that date. An EMG of the right lower extremity showed no abnormalities. Dr. Lesnak was of the opinion that the findings on MRI of the lumbar spine showed that there was no pain generator consistent with Claimant's prior complaints. He determined that Claimant had attained MMI with no permanent impairment and she required no work restrictions.

22. Dr. Lesnak testified that he again evaluated Claimant on October 16, 2008, and his opinion was that Claimant remained at MMI with no permanent impairment. As during his prior examination, Claimant had full range of motion in the lumbar spine. For example, Claimant's forward flexion was 90 degrees whereas it was 90-100 degrees previously, and Claimant could perform a full squat during both examinations.

23. Dr. Lesnak reviewed Dr. Gronseth's DIME report and again examined Claimant on April 20, 2009. Dr. Lesnak testified that he continued to agree with Dr. Gronseth and Dr. Cedillo that Claimant remained at MMI. His examination of Claimant was essentially unchanged except for pain behaviors and submaximal effort during his examination, and he noted the same problems in Dr. Gronseth's DIME. Dr. Lesnak again opined that due to Claimant's pain behaviors and submaximal efforts on examination, range of motion measurements should not have been used for purposes of calculating the permanent impairment rating.

24. Dr. Lesnak testified that, according to the *AMA Guides* and the Division Level II training courses, once something indicates submaximal effort on the part of the patient, then the examiner cannot use range of motion measurements even if the measurements themselves are internally valid. Dr. Lesnak noted that Claimant's anatomic restrictions were inconsistent and varied from provider to provider. He noted that the DIME physician found significant movement restrictions and voluntary guarding on exam. Claimant had multiple pain behaviors and the range of motion inconsistent with prior exams. Dr. Lesnak testified that Claimant's range of motion at the time of the DIME compared to Dr. Ryan's testing, Dr. Cedillo's tests, and the tests conducted by Dr. Lesnak were "quite different" and "wildly different." Thus, the range of motion measurements on one particular day, as in the case of the DIME here, cannot be seen as valid and cannot be utilized for the purpose of calculating an impairment rating.

25. Dr. Lesnak testified with respect to the *AMA Guides* on page 78 which he referenced in his April 20, 2009, report. He stated that when discussing "reproducibility" and range of motion, the *AMA Guides* are referencing all range of motion between providers and throughout the case, not simply reproducibility and consistency on one day of testing. If a claimant's range of motion is wildly different from day to day and from provider to provider, as it was here, even if the range of motion measurements are internally valid during a specific examination, they cannot be considered valid in the overall picture.

26. Dr. Lesnak testified that when physicians are considering range of motion measurements for purposes of determining a permanent impairment rating, they must include the history and mechanism of injury, medical records, diagnostic tests, range of motion measurements from prior examinations, etc. That process is taught in the Level II course and "that's how we do impairment ratings."

27. Dr. Lesnak further testified that although Dr. Gronseth's measurements were at first glance "internally valid" under the *AMA Guides*, the *Guides* also require that inconsistencies documented on previous clinical examinations and during the DIME

measurements must be reconciled. That process is spelled out not only in the *AMA Guides* but also in the Division Interpretive Bulletin and Level II training. The *AMA Guides* require communication with the prior physicians or perhaps further testing to resolve the discrepancy. There is no evidence that Dr. Gronseth did either.

28. The Division requires that further clinical investigation be carried out as generally they do not expect DIME physicians to communicate with treating physicians. Dr. Gronseth did not suggest further diagnostic testing and he did not invalidate the range of motion and request that Claimant return for repeat measurements. Though this would have been a reasonable approach had it been taken, Dr. Lesnak testified that close examination of the prior medical reports and the frequent notation of non-organic findings when coupled with Dr. Gronseth's own documentation of Claimant's inconsistent efforts and non-physiologic findings would have been enough to invalidate the range of motion.

29. Dr. Gronseth did not resolve the discrepancies in the findings prior to issuing his DIME report, he did not discuss any resolution of the discrepancies, and did not request additional testing prior to issuing the impairment rating.

30. Dr. Lesnak testified that Dr. Gronseth's report and examination were not done in accordance with the *AMA Guides* criteria as Dr. Gronseth did not perform the extra step of correlating his findings with the prior examining or treating physicians. Dr. Lesnak noted that the range of motion measurements completed by Dr. Ryan less than two weeks earlier were "wildly different." Furthermore, at MMI and then only a few months earlier in October 2008, there were no range of motion deficits. With respect to Dr. Ryan's findings and opinions, Dr. Lesnak stated that you must read between the lines as the tests are not consistent and are invalid with the medical records. Therefore, the permanent impairment number that Dr. Ryan assigned "doesn't matter" as it was incorrect and not valid.

31. Dr. Lesnak opined at hearing that Dr. Gronseth used range of motion measurements on the day of the DIME only and failed to reconcile the discrepancies in the records and even on his own exam. The impairment must be based on "anatomic restriction" and one cannot use range of motion for purposes of an impairment rating under those circumstances as they were "wrong."

32. Finally, Dr. Lesnak testified that at the time of MMI, Claimant had no permanent impairment and did not qualify for a Table 53 specific disorders rating for the lumbar spine. However, as of Dr. Lesnak's last examination in May 2009, he testified that he agreed with Dr. Gronseth and with Dr. Ryan that Claimant is now entitled to a 5% whole person permanent rating per Table 53 of the *AMA Guides*.

CONCLUSIONS OF LAW

The DIME physician must rate impairment in accordance with the provisions of the *AMA Guides*. Section 8-42-101(3.7), C.R.S.; Section 8-42-107(8)(c), C.R.S.; *Wilson v. Industrial Claim Appeals Office*, 81 P.3d 1117 (Colo.App. 2003). Whether the DIME physician properly applied the *AMA Guides*, and ultimately whether the rating has been

overcome by clear and convincing evidence, are issues of fact. *Wackenhut Corp. v. Industrial Claim Appeals Office*, 17 P.3d 2002 (Colo.App. 2000).

Clear and convincing evidence is that quantum and quality of evidence which renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician's finding concerning impairment is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo.App. 1995). The question of whether the party challenging the DIME physician's finding regarding MMI has overcome the finding by clear and convincing evidence is one of fact.

Where it is determined that the DIME physician's rating has been overcome, the question of the claimant's correct impairment rating then becomes a question of fact. The only limitation is that the findings must be supported by the record and be consistent with the *AMA Guides* and other rating protocols. Thus, once it is determined that the DIME's rating has been overcome, the claimant's impairment rating is based upon the lesser burden of a preponderance of the evidence. *Garlets v. Memorial Hospital*, W.C. No. 4-336-566 (ICAO, September 5, 2001). It is not required that the overall impairment rating be dissected the into its numerous component parts and determine whether each part or sub-part has been overcome by clear and convincing evidence. *Diaz Deleon v. Whole Foods Market, Inc.*, W.C. No. 4-600-477 (ICAO, November 16, 2006).

The purpose of the Workers' Compensation Act of Colorado, Sections 8-40-101, C.R.S., *et seq*., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102 (1), C.R.S. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of the respondents. Section 8-43-201 C.R.S.

A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The Judge's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The Judge need not address every piece of evidence or every inference that might lead to conflicting conclusions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P. 3d 385 (Colo.App. 2000).

In deciding whether a party has met the respective burden of proof, the Judge is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo.App. 2002).

Respondents assert that they have overcome the DIME opinion of Cliff Gronseth, M.D., by clear and convincing evidence. Dr. Gronseth improperly applied, or failed to apply, the *AMA Guides* and Division Level II training when he utilized and included invalid range of motion measurements in the overall permanent impairment rating he assigned for Claimant's lumbar spine condition on January 27, 2009. This is not a question of range

of motion discrepancies between treating physicians and the DIME findings, nor which range of motion measurements are more accurate. Rather, the issue presented is whether range of motion measurements should have been included in the DIME rating in the first instance.

The issue is driven by inconsistencies in Claimant's presentation, inconsistent statements Claimant made to her treating physicians regarding her subjective reports of pain, and inconsistent physical examinations including range of motion measurements. According to the *AMA Guides*, the Division's Level II training, and Dr. Lesnak's credible expert medical opinion, Dr. Gronseth should not have used abnormal lumbar spine range of motion for purposes of calculating Claimant's permanent impairment. First, Dr. Gronseth improperly relied upon, without explanation, range of motion measurements that were not clinically correlated on physical examination and were discrepant when compared with the medical record as a whole. Claimant's presentation from one day to the next, and from one physician to the next, were "wildly" inconsistent and "different" as Dr. Lesnak described in his testimony. For example, on the date of MMI, both Dr. Lesnak and P.A. Schmidt noted that Claimant had no range of motion deficits and there was no basis for a permanent impairment rating or permanent work restrictions.

The conclusions of Dr. Lesnak and P.A. Schmidt remained true on October 16, 2008, when Dr. Lesnak conducted a follow-up examination of Claimant. However, only three months later, in January 2009, Claimant presented to Dr. Ryan and then to Dr. Gronseth with restricted range of motion. Even those deficits and Claimant's presentation between Dr. Ryan and Dr. Gronseth were "wildly different" despite the examinations being only twelve days apart.

Dr. Gronseth included measurements which, while they may have been "internally valid" on the day the DIME was completed, were not "valid" according to the examinations and analysis of the treating physicians, including Dr. Lesnak. For example, Dr. Gronseth noted that Claimant's straight leg raise test on the right at the time of the DIME was limited to four degrees, while twelve days prior at the IME with Dr. Ryan it was up to 20 degrees. Dr. Gronseth made no attempt to reconcile the discrepancy and included the unexplained deficits. In Dr. Lesnak's opinion, the measurements Dr. Gronseth performed regarding loss of range of motion for lumbar flexion and extension were not reasonable and were inconsistent with the medical history.

Based on the discrepancies in the medical record compared to Dr. Gronseth's findings, Dr. Gronseth was obliged under the *AMA Guides* to either further investigate the findings through comparison with prior medical records or to further clinically evaluate the measurements before relying upon them. One way to accomplish this would be to look closely at the clinical data over the last six to twelve months. There is no instance in his report where Dr. Gronseth discussed the differences between his findings and those of the treating physicians and Dr. Ryan. Dr. Gronseth made no attempt to reconcile the significant discrepancies in the record. He simply, and improperly, applied the range of motion deficits he found on the date of the DIME.

Second, the range of motion measurements that Dr. Gronseth found were not consistent even within his own examination. Dr. Gronseth found that Claimant had "significant movement restrictions and voluntary guarding" on exam, 3/5 positive Waddell's signs, and pain behaviors. He stated in his report that, "It is difficult to discern fact from fiction in this claim." He further documented that Claimant "reports to me that this is her current average daily pain level and yet her mannerisms are almost incompatible with functional living. Dr. Gronseth improperly included range of motion measurements when Claimant's efforts were clearly submaximal and unexplained.

Dr. Gronseth found nonorganic findings upon physical examination. Dr. Lesnak credibly testified that such findings would be a sufficient reason, even absent other evidence, to invalidate the range of motion measurements and perform additional investigation prior to assigning medical impairment for the loss of range of motion. At that point, the *AMA Guides* require an explanation by the physician performing the rating. Dr. Gronseth provided no explanation for Claimant's submaximal and diminished efforts and presentation, and he did not reconcile the discrepancies in the medical history. Dr. Lesnak credibly testified that inclusion of range of motion measurements under such circumstances is improper and "wrong", and invalidates the impairment rating Dr. Gronseth provided.

Third, Dr. Gronseth found no objective evidence and he could not provide an explanation for Claimant's alleged lumbosacral sprain/strain and possible right sacroiliac disorder. Dr. Gronseth's impression was documented as, "Query symptom magnification/functional overlay." He noted that, "the inconsistencies on today's presentation compared to the prior notes are significant. She does not demonstrate any clear objective radiculopathy type picture from the lumbar disc degeneration seen on MRI. She appears to have a mechanical type pain, perhaps from sacral disorder…There is no objective evidence for nerve damage, or any leg problems…this is her current average daily pain level and yet her mannerisms are almost incompatible with functional living."

Despite the lack of objective evidence, and without further explanation even though Dr. Gronseth documented the significant discrepancies in the record, Dr. Gronseth improperly included invalid range of motion measurements in the permanent impairment rating that he assigned. Dr. Lesnak credibly testified, and in his April 20, 2009, report stated that, according to the *AMA Guides* and the Division's Level II training, any range of motion measurements of the lumbar spine as noted by Dr. Gronseth cannot be utilized for the purpose of an impairment rating. Dr. Cedillo agreed with Dr. Lesnak's assessment both with respect to invalidity of the DIME rating and permanent impairment.

When the record in this matter is considered as a whole, there is substantial doubt regarding the correctness of Dr. Gronseth's impairment rating. Dr. Gronseth failed to properly apply the *AMA Guides* and the Division Level II training regarding use of invalid range of motion and calculating permanent impairment.

From the evidence presented, it is highly probable that the ratings Claimant received after October 20, 2008, were either based on a worsening of condition after MMI, or symptom

magnification and sub-maximum effort. Respondents have established by clear and convincing evidence that the rating of the DIME physician was incorrect.

Claimant has failed to establish by a preponderance of the evidence that she sustained any permanent impairment as a result of the compensable injury. Claimant is not entitled to any permanent partial disability benefits.

ORDER

It is therefore ordered that Insurer is not liable for permanent partial disability benefits.

DATED: *July 21, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-647-380

ISSUES

Claimant seeks to reopen the underlying workers' compensation claim based upon a worsening of condition.

FINDINGS OF FACT

1.Claimant suffered an admitted work related injury to his left shoulder while working for the Respondent-Employer on March 22, 2005.

2.During treatment by Dr. Ogrodnick it was noted on May 5, 2005, that the results of Claimant's MRI indicated "a short high-grade partial tear of the rotator cuff, subscapularis tendinosis and a minimal acromial spurring."

3.Claimant received a steroid injection on May 5, 2005.

4.On May 19, 2005 Claimant was examined and found to have full rotator cuff strength. Claimant was still experiencing pain in his left shoulder and Claimant received a prescription for 800 mg of Motrin and Vicodin. Claimant was then referred to orthopedics.

5.Claimant received steroid injections from Dr. Walden, the orthopedist.

6.Claimant was placed at maximum medical improvement for this injury on August 15, 2005 and a final admission of liability (FAL) was filed on September 30, 2005.

7.Subsequent to the filing of the FAL Claimant has not experienced any events, traumatic or otherwise, to his left shoulder area that would necessitate an analysis concerning subsequent intervening events.

8.Claimant had an MRI of his left shoulder completed on July 8, 2008. This MRI indicated that Claimant's left shoulder condition had worsened over time since being placed at MMI. This MRI was accomplished at the request of Claimant's primary care physician, Dr. Bird.

9.On August 4, 2008 Claimant underwent left shoulder surgery by Dr. Devanny.

10.The surgery revealed that Claimant's original tear had worsened.

11.On November 12, 2008 Claimant filed a petition to reopen.

12.Notice of the hearing herein was provided to the Respondent-Insurer by certificate of service dated April 9, 2009. Claimant verified the address being used for the Respondent-Insurer.

13.Respondents did not appear in person or through representation.

14.Claimant was allowed to present his case as notice was proper and the Claimant had the burden of proof.

15.Claimant testified at hearing and the ALJ finds Claimant to be credible.

16.Claimant has established by a preponderance of the evidence that as of July 08, 2008 Claimant's original workers' compensation injury from March 22, 2005 had worsened subsequent to being placed at MMI on August 15, 2005.

17.Claimant's request to reopen his claim herein is appropriate.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

1.The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of

the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

2.When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The ALJ's factual findings concern only evidence and inferences that are found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

3.The Claimant seeks to reopen W.C. No. 4-647-380 (March 22, 2005 injury) based on a worsened condition. The Claimant implicitly contends that as a direct and proximate result of the left shoulder injury he was left in a weakened condition that ultimately worsened.

4.Section 8-43-303(1), *C.R.S.*, provides that an award may be reopened on the ground of, *inter alia*, change in condition. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, *supra*; *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in Claimant's physical or mental condition, which can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985). Reopening is warranted if the Claimant proves that additional medical treatment is needed. *Richards v. Industrial Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000); *Dorman v. B & W Construction Co.,* 765 P.2d 1033 (Colo. App. 1988).

5.Colorado recognizes the "chain of causation" analysis holding that results flowing proximately and naturally from an industrial injury are considered to be compensable consequences of the injury. Thus, if the industrial injury leaves the body in a weakened condition and the weakened condition plays a causative role in producing additional disability the disability is a compensable consequence of the industrial injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); *Price Mine Service, Inc. v. Industrial Claim Appeals Office,* 64 P.3d 936 (Colo. App. 2003); *Jarosinski v. Industrial Claim Appeals Office, supra*.

6.The ALJ concludes the Claimant proved it is more probably true than not that the March 22, 2005 industrial injury to the Claimant's left shoulder caused a weakened condition (inability to use the left upper extremity because of pain and restriction) that existed when the Claimant returned to work after being placed at MMI. The weakness of the left shoulder ultimately caused a deterioration of Claimant's left shoulder condition. Therefore, the ALJ concludes the Claimant proved a worsened condition causally-related to the original industrial injury of March 22, 2005, and that the Claimant now needs additional medical treatment as a result of the worsening of condition.

7.In reaching this conclusion the ALJ credits the testimony of the Claimant. The ALJ concludes the Claimant's testimony is corroborated by the medical reports of Dr. Devanny, as well as the MRI's completed in 2005 and 2008.

8.The ALJ concludes that as of July 08, 2008 Claimant was no longer at MMI and needed a referral to an orthopedic surgeon for evaluation and treatment. Thus, the Claimant has shown it is more probably true than not that the worsened condition has resulted in the need for medical treatment.

ORDER

It is therefore ordered that:

1.The Claimant's petition to reopen W.C. No. 4-647-380 is granted.

2.The Respondent-Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

3.All matters not determined herein are reserved for future determination.

DATE: July 22, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-676-410

ISSUES

The issue to be determined by this decision is the following:

Whether Respondents April 4, 2008 Final Admission of Liability should be stricken as being *void ab intio.*

FINDINGS OF FACT

1. Claimant sustained an admitted work injury to his right shoulder on August 16, 2005 while working for the Respondent-Employer.

2. Claimant was initially placed at MMI on May 23, 2007 by Dr. Reasoner. Dr. Richman conducted a Division IME on August 29, 2007 and found further testing necessary, taking Claimant off of MMI. Respondents filed a general admission consistent with Dr. Richman's report. A complete copy of Dr. Richman's August 29, 2007 Division IME report was attached to the general admission of liability.

3. Additional treatment consistent with the recommendations of Division IME was completed by Dr. Reasoner. A request and notification for "Follow-up IME" was requested on February 21, 2008. The notice provided Claimant and his attorney with the date of the follow-up appointment with the Division IME – March 26, 2008.

4. Dr. Richman reexamined Claimant on March 26, 2008 and concluded Claimant had reached MMI with impairment on November 9, 2007. The Division IME's report consisted of 4 pages, including an "IME Examiner's Summary Sheet" and a 3 page narrative report. The report did not include any "worksheets."

5. Dr. Richman testified that he did not complete range of motion worksheets as part of his March 26, 2008 Division IME. Dr. Richman testified Claimant had range of motion deficits on March 26, 2009 similar to the range of motion found in his earlier examination of Claimant on August 29, 2007 when he found Claimant not at MMI and in need of additional treatment. Claimant's lack of response to the treatment he suggested led Dr. Richman to conclude Claimant's impairment was greater than the impairment that would have been found had he used only Claimant's range of motion deficits. Under Dr. Richman's measurements, Claimant would be entitled to a 15% upper extremity rating. Dr. Richman did not believe this would adequately address the impairment sustained by Claimant with this injury - a massive inoperable rotator cuff tear in his right shoulder.

6. Because impairment based on range of motion deficits did not adequately address Claimant's impairment in his opinion, Dr. Richman looked elsewhere in the AMA Guides for a suitable impairment scheme for Claimant's right shoulder injury that would increase the amount of impairment given to Claimant beyond that which would have been provided if he used range of motion to address impairment. Dr. Richman opined through his Level 2 training and his review of the AMA Guides that page 52 of the AMA Guides under "Other musculoskeletal system defect" allowed for him to give Claimant a higher impairment rating for his inoperable rotator cuff tear. Dr. Richman noted that the example on page 52 described Claimant's condition well. Dr. Richman opined that Table 19 of the AMA Guides better addressed Claimant's massive rotator

cuff tear than using range of motion deficits. Table 19 provides impairment for joints following arthropathy and, while Claimant did not have that surgery, his shoulder was comparable to a person following shoulder arthropathy. Dr. Richman opined this rating was consistent with the directions at page 52 of the AMA Guides.

7. Dr. Richman found a 30% upper extremity impairment rating was more accurate than impairment based on Claimant's loss of range of motion. The rating was not predicated on Claimant's range of motion deficits. Impairment based on range motion deficits would have left Claimant with a smaller impairment rating. Dr. Richman opined that range of motion deficits of Claimant's shoulder did not reflect the true extent of musculoskeletal defect. He therefore used the discretionary guidance at page 52 of the AMA Guides to give Claimant a greater impairment rating.

8. Dr. Richman testified his rating was not predicated on Claimant's range of motion deficits, so no range of motion worksheet was completed or attached to his Division IME report.

9. Dr. Richman testified that the report attached to Respondents FAL at Respondents' C was a complete and accurate copy of his March 26, 2008 report. Dr. Richman testified that he received notice from the Division of Workers' Compensation that his Division IME was "complete."

10. The parties stipulated that Respondents' C was a complete copy of the FAL with attachments as filed by respondents on April 4, 2008.

11. No objection or application for hearing was filed in response to the April 4, 2008 FAL and the claim closed on May 4, 2008.

12. After the claim closed, Claimant, through counsel, filed a motion on June 20, 2008 to set aside the April 4, 2008 FAL. In the motion, Claimant alleged respondents "did not attach to the final admission of liability the worksheets completed by the Division IME." Respondents objected to the motion to set aside the FAL, indicating the report attached to the FAL was not "incomplete." Prehearing ALJ Jaynes initially granted Claimant's motion on July 3, 2008.

13. Respondents' filed a motion to reconsider Prehearing ALJ Jaynes' Order, indicating Claimant's assumption that worksheets were completed but not attached to the FAL was erroneous. The Division IME's office indicated no worksheets were completed in conjunction with the Division IME's March 26, 2008 report and that the 4 page report attached to the FAL was the complete report of the Division IME. Judge Jaynes reversed his prior order and issued an order denying Claimant's motion to set aside the FAL on August 15, 2008.

14. On November 12, 2008, Claimant filed an application for hearing on the issue of his motion to set aside the April 4, 2008 FAL. Respondents filed a response to application for hearing asserting the claim is closed, that the FAL was properly filed,

and that Judge Jaynes had issued an order denying the relief requested by Claimant.

15. Claimant filed another application for hearing on the same issue on February 5, 2009. Respondents filed a response to application for hearing on February 23, 2009, again asserting the claim is closed, that the FAL was properly filed, and that Judge Jaynes had issued an order denying the relief requested by Claimant. The matter was set for hearing in Colorado Springs on May 27, 2009 at 1:30 p.m. and was completed the same day. The parties were given the opportunity to provide position statements to the ALJ. Both parties submitted position statements. A Summary Order denying Claimant's request that the April 4, 2008 FAL be stricken as *void ab initio* was served on July 7, 2009. Claimant timely requested specific findings of fact, conclusions of law and order.

16. Dr. Richman testified credibly that his impairment rating was not predicated on range of motion deficits found in Claimant's shoulder and, therefore, he did not complete range of motion worksheets as part of his March 26, 2008 Division IME report. Dr. Richman found a 30% upper extremity impairment rating was more accurate than impairment based on Claimant's loss of range of motion. Dr. Richman opined Claimant's impairment was 30% of the upper extremity. The rating was not predicated on Claimant's range of motion deficits. Impairment based on range motion deficits would have left Claimant with a smaller impairment rating. Dr. Richman opined that range of motion deficits of Claimant's shoulder did not reflect the true extent of musculoskeletal defect. He therefore used the discretionary guidance at page 52 of the AMA Guides to give Claimant a greater impairment rating.

17. The claim was closed by the FAL filed by Respondents on April 4, 2008, which attached a complete copy of the Division IME's March 26, 2008 report. Claimant has failed to prove that the FAL is void or that it should be set aside.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40- 102 (1), C.R.S. A Claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark, 197 Colo.* 306, 592 P.2d 792 (1979); People v. M.A., 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to

a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-43-203(2) (b) (II), C.R.S. provides, in relevant part, that a claim "will be automatically closed as to the issues admitted in the final admission if the Claimant does not, within thirty days after the date of the final admission, contest the final admission in writing and request a hearing on any disputed issues that are ripe for hearing . . .". Once a claim has been closed it may only be reopened on the grounds stated in §8-43-303, C.R.S.; *see Peregroy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004).

5. As found, Claimant did not object or apply for a hearing on all ripe issues within 30 days of the filing of the April 4, 2008 FAL. As a result, Claimant's claim closed by operation of law with regard to all issues on May 4, 2008.

6. Nevertheless, Claimant asserts that, because the April 4, 2008 was *void ab initio*, his claim remained open. Section 8-43-203(2) (b) (II), C.R.S. provides that when a FAL "is predicated upon medical reports, such reports shall accompany the final admission." One of the purposes of §8-43-203(2)(b)(II), C.R.S. is to provide a Claimant with notice regarding the exact basis of admitted or denied liability so that he can make an informed decision about whether to challenge the FAL. *Silva v. Poudre School Dist.*, W.C. No. 4-651-643 (ICAP, Apr. 30, 2008).

7. W.C.R.P. Rule 5-5(A) also provides that when a FAL is predicated upon medical reports, the reports, along with the worksheets or other evaluation information associated with an impairment rating, shall accompany the FAL. Therefore, when a medical report is not attached to a FAL, the FAL is insufficient to close the claim. *Avila v. Universal Forest Prod.*, W.C. No. 4-477-247 (ICAP Aug. 25, 2004).

8. As found, Respondents complied with both §8-43-203(2)(b)(II) and W.C.R.P. Rule 5.5(A) in filing the April 4, 2008 FAL. Respondents attached a complete copy of the Division IME's report to the April 4, 2008 FAL. Claimant's argument that non-existent range of motion worksheets must be attached in order for the FAL to be valid is without merit.

9. The Division IME's impairment rating was not predicated on Claimant's range of motion deficits. The Division IME did include the range of motion measurements in the body of his Division IME report, but did not complete a range of motion worksheet

because he opined the range of motion deficits would have been inadequate to address the extent of Claimant's impairment.

10. Using the discretionary authority found in the AMA Guides at page 52 under "Other musculoskeletal system defects," Dr. Richman opined an impairment rating based Claimant's massive rotator cuff tear was better addressed by Table 19 of the AMA Guides. Table 19 provides impairment for joints following arthropathy. Impairment based on range motion deficits would have left Claimant with a smaller impairment rating. Dr. Richman opined that range of motion deficits of Claimant's shoulder did not reflect the true extent of musculoskeletal defect. He therefore used the discretionary guidance at page 52 of the AMA Guides to give Claimant a greater impairment rating.

11. The claim was closed by the FAL filed by Respondents on April 4, 2008, which attached a complete copy of the Division IME's March 26, 2008 report. Claimant has failed to prove that the FAL is void or that it should be set aside.

ORDER

It is therefore ordered that:

Claimant's request to strike the final admission of liability as being *void ab initio* is denied and dismissed.

Any and all issues not determined herein are reserved for future decision.

DATE: July 22, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-679-362

ISSUES

- Did the claimant prove by clear and convincing evidence that the Division-sponsored independent medical examination physician incorrectly apportioned the claimant's permanent impairment rating based on a prior injury?

- What is the claimant's average weekly wage considering that the claimant became disabled more than two years after the date of the injury?

- Is the claimant entitled to an award of disfigurement benefits and, if so, how much?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

This matter was submitted without the presentation of any live testimony concerning the substantive issues of permanent disability and average weekly wage. At the hearing only the claimant's attorney, Mr. Morrell appeared. Mr. Morrell stated that he would work with respondent's counsel concerning the submission of agreed upon exhibits. On July 10, 2009, the attorneys for both parties submitted a signed Stipulation agreeing that the ALJ shall consider as evidence Claimant's Exhibits 1 through 4 and Respondent's Exhibits A through I. These documents shall be considered by the ALJ.

The claimant sustained a compensable low back injury on February 8, 2006, while employed as a brisket bone operator for the employer. The February 8, 2006 injury is the subject of this claim.

The claimant sustained a prior industrial injury to his low back on September 19, 2001, while working for the employer. An MRI performed in December 2001 revealed a left-sided disk protrusion at L4-L5 and a large left disk herniation at L5-S1. Dr. Robert Thiel, M.D., treated the claimant for the 2001 injury and placed him at maximum medical improvement (MMI) on March 21, 2002. Dr. Thiel assessed a 14 percent whole person impairment consisting of 7 percent impairment for reduced range of motion in the lumbar spine (4 percent lumbar flexion, 2 percent lumbar extension, 0 for right lateral flexion, 1 percent left lateral flexion) and 7 percent impairment for a specific disorder of the lumbar spine.

Dr. Thiel, also treated the claimant for the February 2006 industrial injury. Following a course of conservative treatment, Dr. Thiel initially placed the claimant at MMI on February 13, 2007.

On July 25, 2007, Dr. Erasmus Morfe, D.O., performed a Division-sponsored independent medical examination (DIME). Dr. Morfe noted that the most recent MRI of May 10, 2006, showed broad-based disk protrusions at L4-5 and L5-S1, moderate and left lateral stenosis at L4-5, and displacement of the traversing nerve roots. Dr. Morfe opined the claimant was not at MMI because he had failed conservative therapy and demonstrated significant pathology on MRI. Dr. Morfe recommended the claimant be evaluated for surgery. However, Dr. Morfe also assessed a 16 percent whole person impairment rating (8 percent for specific disorders of the lumbar spine and 8 percent for range of motion impairment). The specific disorders impairment was based on "multilevel lumbar pathology." (Respondents' Exhibit D page 5; Claimant's Exhibit 1 page 5). At that time Dr. Morfe apportioned 14 percent of the impairment to the claimant's 2001 injury resulting in an overall impairment of 2 percent for the 2006 injury. However, Dr. Morfe's finding

that the claimant was not at MMI was not challenged and the claimant was returned to the authorized providers for further treatment.

On May 19, 2008, Dr. Hans Coester, M.D., performed surgery consisting of a left sided L4-5 semi-hemilaminectomy and diskectomy.

Dr. Thiel once again placed the claimant at MMI on September 2, 2008. The claimant then returned to Dr. Morfe for a follow-up DIME on November 4, 2008.

In his follow-up DIME report dated November 4, 2008, Dr. Morfe stated the claimant was feeling "quite a bit better" despite some left leg cramping. Dr. Morfe noted that Dr. Thiel placed the claimant at MMI on September 2, 2008, and assessed 15 percent whole person impairment without apportionment. According to Dr. Morfe, Dr. Thiel correctly calculated the claimant's range of motion impairment at 6 percent. In fact, Dr. Morfe stated that because there was no significant change in the claimant's overall condition since his last measurements, he would rely on Dr. Thiel's September 2008 range of motion measurements. However, Dr. Morfe stated that he believed Dr. Thiel might have erroneously calculated the specific disorder rating by relying on the Table 53 rating for cervical impairment rather than lumbar impairment.

Dr. Morfe rated the claimant's overall impairment as 15 percent whole person based on 6 percent impairment for lumbar range of motion and 10 percent impairment for a specific disorder of the lumbar spine resulting from a surgically treated disk with residual symptoms. However, unlike Dr. Thiel, Dr. Morfe determined that 14 percent of the overall impairment rating must be apportioned to the 2001 injury. Dr. Morfe stated that the claimant had a "documented work related injury" in 2001 and that Dr. Thiel had given the claimant a 14 percent whole person impairment rating for the 2001 injury.

The claimant failed to prove it is highly probable and free from serious doubt that Dr. Morfe improperly apportioned the claimant's impairment rating based on the 2001 injury. First, the ALJ notes that the claimant failed to produce any qualified medical testimony or evidence specifically criticizing or disputing Dr. Morfe's apportionment. The ALJ finds the absence of any direct medical testimony or evidence tending to challenge Dr. Morfe's apportionment to be persuasive evidence that the claimant has not overcome Dr. Morfe's impairment rating and apportionment.

Second, the only physician besides Dr. Morfe that might have considered the apportionment issue is Dr. Thiel. However, the record does not contain Dr. Thiel's report of September 2, 2008, and it is impossible to determine why he thought that no apportionment is appropriate, or why he might believe that Dr. Morfe misapplied the AMA Guides and related protocols in deciding to apportion. Therefore, insofar as Dr. Thiel's September 2008 impairment rating, which is mentioned in Dr. Morfe's November 4, 2008 DIME report, could be considered some evidence that Dr. Morfe's decision to apportion was incorrect, the ALJ finds that evidence unpersuasive and not of sufficient weight to overcome Dr. Morfe's rating, including the apportionment.

Third, because the record does not contain Dr. Thiel's September 2, 2008 report, it is impossible to ascertain the specific lumbar range of motion measurements that he observed and recorded on that date. All that can be said for certain is that Dr. Thiel found the claimant's overall lumbar range of motion, as measured on September 2, 2008, was 1 percent better than it was in 2002.

Fourth, although the claimant's position statement relies on range of motion measurements purportedly taken by Dr. Thiel on September 2, 2008, and argues that these measurements demonstrate decreased range of motion (in three planes) when compared to 2002, the record does not support the claimant's position. In the absence of medical records or other evidence establishing Dr. Thiel's actual range of motion measurements, there is no credible or persuasive evidentiary basis to support the claimant's assertion. In fact, the ALJ notes that the claimant's position statement appears to compare the claimant's 2002 range of motion measurements to measurements taken by Dr. Morfe on July 25, 2007, not to the measurements taken by Dr. Thiel on September 2, 2008.

Fifth, although Dr. Morfe determined that the claimant was assessed 7 percent impairment for a specific disorder of the lumbar spine related to the 2001 injury, and Dr. Morfe assessed a 10 percent specific disorder impairment after the 2006 injury, that fact alone does constitute clear and convincing evidence that Dr. Morfe was required to find that the claimant's overall impairment rating had increased by three percent since 2002. As noted, the claimant failed to produce any credible medical evidence or testimony supporting this argument. Moreover, it is possible for the ALJ to hypothesize explanations, other than error on the part of Dr. Morfe, to support Dr. Morfe's decision not to apportion. For instance, it might be that Dr. Morfe believed that the 2001 impairment rating itself was incorrect in that it did not assign sufficient impairment for the resulting specific disorder. In this regard, the ALJ notes that the record contains substantial evidence that the 2001 injury involved multiple disk levels of the lumbar spine, but Dr. Thiel's impairment rating was apparently assigned for a single level. Indeed, when Dr. Morfe assigned his rating in 2007, before the surgery, he assigned a rating for multiple levels. Of course, such a supposition amounts to no more than speculation by the ALJ. The fact remains that the claimant produced no credible or persuasive medical evidence that supports a finding that Dr. Morfe erred in apportioning the impairment rating.

The employer's first report of injury for the 2006 injury reflects an average weekly wage (AWW) of $448.

The respondent's Final Admission of Liability (FAL) dated June 17, 2009, reflects an admitted AWW of $439.60. The FAL also reflects that the respondent admitted the claimant was entitled to temporary total and temporary partial disability benefits for the period of May 19, 2008, through September 1, 2008. The period of admitted temporary disability coincides with the period of time from the date the claimant underwent surgery to the date he was placed at MMI.

Claimant's Exhibit 4 contains a copy of pay data showing the claimant's earnings for the week ending May 18, 2008, as well as his total (year to date) earnings for calendar 2008.

The year to date data shows the claimant had earned gross pay of $10,734.58 as of May 18, 2008. As of May 18, 2008, 139 days had elapsed during calendar 2008.

Dividing $10,734.58 by 139 days results in average daily earnings of approximately $77.227 during calendar 2008. Multiplying the daily earnings times 7 yields and average weekly wage of $540.59.

The ALJ finds the calculation set forth in Finding of Fact 18 represents a fair method of determining the claimant's AWW as of May 19, 2008. In this regard the ALJ finds that for the calendar year 2008 the claimant had been earning an AWW significantly higher than the admitted AWW of $439.60. The ALJ finds that considering the significant lag in time between the date of injury and the commencement of disability in May 2008, and considering the substantial increase in earnings the claimant was receiving in May 2008 compared to February 2006, it would be manifestly unfair to base the claimant's AWW, and consequently his temporary and permanent disability benefits, on the earnings he was receiving on the date of the original injury.

The ALJ finds the claimant's AWW is $540.59.

As a result of the injury sustained on February 8, 2006, the claimant sustained a serious permanent disfigurement to areas of his body normally exposed to public view. The disfigurement consists of a linear scar located on the claimant's back just above the belt line. The scar is approximately 3 inches in length.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Except as specifically noted below, the claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and

inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

DIME PHYSICIAN'S APPORTIONED IMPAIRMENT RATING

The claimant argues that the DIME physician, Dr. Morfe, incorrectly apportioned the impairment rating for the 2006 injury based on the rating given for the 2001 injury. The claimant notes that under WCRP 12-3(A), apportionment of impairment for injuries occurring prior to July 2008 requires that the evidence substantiate "preexisting impairment to the same body part," and that such preexisting impairment be measured as it existed "at the time of the subsequent injury." The claimant argues that Dr. Morfe disregarded these principles by deducting all of the claimant's 2001 impairment rating from the rating for the 2006 injury. Specifically the claimant argues that the 2006 injury resulted in 3 percent greater impairment for specific disorder of the lumbar spine and 3 percent additional impairment for reduced range of motion. The ALJ concludes that the claimant failed to overcome Dr. Morfe's apportionment by clear and convincing evidence.

As a general matter, all impairment ratings must be determined in accordance with the rating protocols of the AMA Guides. Section 8-42-101(3.7), C.R.S.; § 8-42-107(8)(c) C.R.S.; *Wilson v. Industrial Claim Appeals Office,* 81 P.3d 1117 (Colo. App. 2003). In order to rate medical impairment a physician must earn level II accreditation in accordance with § 8-42-101(3.6)(b), C.R.S. The finding of a DIME physician concerning the claimant's impairment rating is binding unless overcome by clear and convincing evidence. Section 8-42-107(8)(c); *Wilson v. Industrial Claim Appeals Office, supra.*

Section 8-42-104(2)(b), C.R.S. (recently amended with respect to injuries occurring on or after July 1, 2008) provides:

> Where benefits are awarded pursuant to §8-42-107, an award of benefits for an injury shall exclude any previous impairment to the same body part.

Under this statute apportionment based on preexisting impairment is one of the causation issues inherent in the DIME physician's impairment rating. Consequently, the DIME physician's decision whether to apportion is a "pure medical determination" subject to the clear and convincing standard. *Martinez v. Industrial Claim Appeals Office,* 176 P.3d 826 (Colo. App. 2007). Similarly, the propriety of the DIME physician's application of the rating protocols of the AMA Guides to arrive at an apportionment decision must be overcome by clear and convincing evidence. *See McLane Western, Inc. v. Industrial Claim Appeals Office,* 996 P.2d 263 (Colo. App. 1999).

Clear and convincing evidence is that quantum and quality of evidence that renders a factual proposition highly probable and free from serious or substantial doubt. Thus, the party challenging the DIME physician's apportionment must produce evidence showing it highly probable the DIME physician's apportionment determination is incorrect.

Metro Moving and Storage Co. v. Gussert, 914 P.2d 411 (Colo. App. 1995). The issue of whether a party has overcome the DIME physician's rating is one of fact rather than law. *Wilson v. Industrial Claim Appeals Office, supra.*

The AMA Guides provide that apportionment of medical impairment is appropriate only if the prior impairment has been sufficiently identified, treated, or evaluated to be rated as a contributing factor in any subsequent disability. Apportionment based on a preexisting condition is not proper unless there is sufficient information to accurately measure the change in impairment. *Askew v. Industrial Claim Appeals Office,* 927 P.2d 1333, 1338 (Colo. 1996)*; Martinez v. Industrial Claim Appeals Office, supra*. Consistent with this principle WCRP 12-3 provides that a Level II physician shall apportion preexisting medical impairment "where medical records or other objective evidence substantiate" the pre-existing impairment, and the physician shall "fully explain" the basis of the apportionment. Further, WCRP 12-3 provides that if "there is insufficient information to measure the change accurately, the Level II accredited physician shall not apportion." Considering these principles, the ICAO has held that the DIME physician's determination of whether documentation of preexisting impairment is sufficient to support apportionment must ordinarily be overcome by clear and convincing evidence. *Hess v. Pinnacle Constructors & Specialties, Inc.,* W.C. No. 4-523-427 (ICAO August 15, 2003); *Campbell v. Department of Corrections,* W.C. No. 4-446-238 (ICAO, November 19, 2002).

The ALJ concludes the claimant failed to prove it is highly probable and free from serious doubt that Dr. Morfe erred in apportioning the claimant's impairment rating for the 2006 injury based on preexisting impairment caused by the 2001 injury. As determined, the only medical opinion tending to offer some support to the claimant's position is that of Dr. Thiel issued in September 2008. However, the record does not contain Dr. Thiel's actual report documenting his findings and explaining his decision not to apportion any of the claimant's impairment rating to the 2001 injury. The ALJ concludes that the bare fact of Dr. Thiel's rating and refusal to apportion does not constitute persuasive evidence establishing it is highly probable that Dr. Morfe's apportionment was incorrect. Moreover, the claimant did not offer into evidence the opinion of a qualified level II physician that criticizes Dr. Morfe's November 4, 2008 impairment rating, or explains how his apportionment determination was incorrect under the AMA Guides and associated rating protocols. The ALJ considers the absence of such evidence to be entitled to great weight in determining that the claimant failed to overcome by clear and convincing evidence Dr. Morfe's rating and apportionment.

As noted, the claimant appears to argue that because Dr. Morfe assigned greater specific disorder impairment for the 2006 injury (10 percent) than was assigned by Dr. Thiel for the 2001 injury (7 percent) it must necessarily follow that Dr. Morfe erred in apportioning more than 7 percent of the specific disorder impairment to the 2001 injury. However, as determined in Finding of Fact 14, acceptance of this argument would require the ALJ to speculate about the precise reasons for Dr. Morfe's rating and his assessment of Dr. Thiel's 2001 rating, and to conclude that Dr. Morfe acted contrary to the AMA Guides and ratings protocols. However, in the absence of qualified medical opinion that would support such a conclusion, the ALJ declines to engage in such speculation. As noted, in *Martinez v. Industrial Claim Appeals Office, supra*, apportionment involves a

"pure medical determination." In the absence of qualified medical opinion from a physician qualified to issue impairment ratings, the ALJ concludes that the claimant has failed to overcome Dr. Morfe's rating and apportionment by clear and convincing evidence.

AVERAGE WEEKLY WAGE CALCULATION

The claimant argues that his AWW should be based on his earnings in 2008 when he became disabled, not the wages he was earning when he in was injured in 2006. The ALJ agrees with this argument.

Section 8-42-102(2), C.R.S., requires the ALJ to base the claimant's AWW on his earnings at the time of injury. However, under certain circumstances the ALJ may determine the claimant's AWW from earnings received on a date other than the date of injury. *Avalanche Industries, Inc. v. Clark,* 198 P.3d 589 (Colo. 2008); *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Specifically, § 8-42-102(3), C.R.S., grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine the claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp., supra.* Where the claimant's earnings increase periodically after the date of injury the ALJ may elect to apply § 8-42-102(3) and determine that fairness requires the AWW to be calculated based upon the claimant's earnings during a given period of disability, not the earnings on the date of the injury. *Avalanche Industries, Inc. v. Clark, supra*; *Campbell v. IBM Corp.*, *supra*.

Exercising the discretion allotted by § 8-42-102(3), the ALJ concludes that the claimant's AWW is $540.59. As determined in Finding of Fact 19, the ALJ finds that the claimant was earning substantially more in wages on May 19, 2008, when his disability commenced, than the respondent admitted he was earning on February 8, 2006, the date of the injury. The ALJ concludes it would be manifestly unfair to base the claimant's AWW on the earnings he was receiving on the date of the original injury rather than the earnings on the date the disability commenced, more than two years after the injury. Moreover, the ALJ finds that the fairest way to calculate the claimant's earning on the date his disability commenced is to consider the total earning in calendar 2008 prior to the commencement of the disability ($10,734.58) and divide by the number of days in 2008 prior to the commencement of the disability (139 days), to arrive at average daily earnings of $77.227. The daily earnings of $77.227 are then multiplied by 7 to arrive at an AWW of $540.59.

DISFIGUREMENT

The claimant seeks an award of disfigurement benefits for the scar described in Finding of Fact 21. The ALJ notes that the claimant's injury occurred prior to the July 1, 2007, effective date of the recent amendments to § 8-42-108, C.R.S. Consequently, any award for disfigurement benefits is limited to a maximum of $2,000.

The ALJ concludes the claimant sustained a serious permanent disfigurement to areas of his body normally exposed to public view, which entitles the claimant to additional compensation. The ALJ concludes the respondent shall pay $1,000 as compensation for the disfigurement.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The respondent shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2. Issues not resolved by this order are reserved for future determination.

3. Because the claimant failed to overcome the DIME physician's apportioned impairment rating, the respondent shall pay permanent partial disability benefits in accordance with its final admission of liability.

4. The claimant's average weekly wage is $540.59.

5. The respondent shall pay compensation for disfigurement in the amount of $1,000. The respondent may take credit for any disfigurement benefits previously paid to the claimant.

DATED: July 22, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-174-355

ISSUES

Should summary judgment be granted in Respondent's favor dismissing with prejudice the Claimant's spouse's claim for dependent benefits based upon W.C. 4-174-355?

For the reasons stated below the ALJ finds that summary judgment is appropriate.

FINDINGS OF UNDISPUTED ISSUES OF MATERIAL FACT

1.Claimant was injured in an incident arising out of and in course of her employment with the Respondent-Employer on April 16, 1993.

2.Claimant filed a workers' compensation claim under W.C. 4-174-355, the claim that is under consideration herein.

3.Claimant received benefits pursuant to that claim and was ultimately determined to be totally and permanently disabled as a result of the work-related injury.

4.On January 19, 2005 Claimant passed away. Pursuant to this event the Respondent-Insurer filed a final admission of liability (FAL) on February 10, 2005. Respondent-Insurer argues that Claimant's spouse did not object to the FAL within the thirty-day time period set out in the statute. Whether or not Claimant's spouse or any other party in interest filed a timely objection to the FAL in W.C. 4-174-355 is not relevant to the decision made hereunder.

5.Claimant's spouse ultimately filed a separate claim, that being W.C. 4-709-876. That claim is not before the ALJ and the ALJ takes no position as to the validity or non-validity of that claim.

CONCLUSIONS OF LAW

1. To the extent that the Claimant's spouse seeks to claim benefits as a wholly dependent or partially dependent individual, Claimant is required to file a separate action with the DOWC. Whether or not the Claimant's spouse has satisfied any requirements to pursue that claim is not before the ALJ in this motion and the ALJ takes no position on that separate claim, W.C. 4-709-876. See section 8-43-103, C.R.S. (2008).

2. The narrow issue in this motion is whether or not claim W.C. 4-174-355 is available as a vehicle for Claimant's spouse to pursue a claim for dependent benefits.

3. The ALJ concludes that Claimant's spouse is not a party to claim W.C. 4-174-355 and he does not have standing to assert dependent benefits pursuant to that claim. Thus, Claimant's spouse did not have to object to the FAL to preserve his own independent claim. See *Hoffman v. Hoffman*, 872 P.2d 1367 (Colo. App. 1986).

4. The ALJ concludes that to the extent that there was an objection to the FAL lodged by Claimant's attorney, that objection has no legal significance vis-à-vis Claimant's spouse's claim under W.C. 4-174-355 and this issue is not before the ALJ. Claimant's spouse had no standing to object to the FAL. Only the Claimant or a proper party in interest could pursue any validly filed objection. The Claimant's spouse did not have a legal interest individually in the claim of Claimant.

Claimant's interests are separate and apart and must follow the statute in terms of filing any individual claim. Section 8-43-203(2)(b)(II), C.R.S. (2008).

5. Since, claim W.C. 4-174-355 was the claim of the Claimant and not the Claimant's spouse, Claimant's spouse may have had an interest in pursuing any claims under that claim number as the heir of the Claimant or as a representative of her estate. Again however, that issue is not before the ALJ.

ORDER

It is therefore ordered that:

1.Respondents' Motion for Summary Judgment is GRANTED. Claimant's spouse's claim for dependent benefits under W.C. 4-174-355 is denied and dismissed.

2.All matters not determined herein are reserved for future determination.

DATE: July 23, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-761-479

ISSUE

The issue whether Claimant injured himself in the course and scope of his employment was raised for consideration at hearing.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statement, the following Findings of Fact are entered.

1. The Employer is located on the Western Slope of Colorado with a company mailing address in Loma, Colorado, 10 miles east of the Utah border. The Employer provides "dirt work" for oil drilling companies on the Western Slope, including building flat pads for oil rigs and access roads for digging sites. The Employer only provides these services on the Western Slope.

2. Claimant is a 32 year old male, who was hired as a heavy equipment operator by the Employer in September 2007. Prior to being hired, Claimant lived in Kersey, Colorado, which is on the Front Range, close to Greeley, Colorado.

3. After obtaining a job with the Employer, Claimant voluntarily moved to Battlement Mesa on the Western Slope. Battlement Mesa is in a central area on the Western Slope, close to the job site locations where Claimant worked for the Employer. Claimant moved to Battlement Mesa to be closer to his new job. Claimant was not induced by the Employer to move to the Western Slope with promises of special treatment. The Employer did not request that Claimant move to the Western Slope, the Employer did not pay for Claimant's move to the Western Slope, and the Employer did not pay for Claimant's lodging or meals during the period Claimant worked for the Employer. Although Claimant moved to Battlement Mesa, Claimant's family stayed in Kersey. Claimant told Scott Brady (Brady), who is the President and Owner of the Employer, that Claimant planned to move his family to the Western Slope eventually. Claimant's residence during the period he worked for the Employer was Battlement Mesa.

4. Claimant worked for the Employer between September 2007 and April 24, 2008. Claimant worked as a heavy machine operator, primarily operating bulldozers. Claimant was paid for work performed while on the clock, and Claimant was only on the clock during the times he was operating a machine, such as a bulldozer. Claimant was not paid for his travel from his home in Battlement Mesa to the Western Slope work sites.

5. Claimant received $50 per day in truck rent from the Employer's use of his truck, but only on the days that Claimant worked. Claimant's truck had an extra fuel tank, and Claimant could transport fuel to the work site in his truck. Claimant was authorized by Employer to fill his truck with gas purchased on Employer's commercial fuel account. Claimant was expected to use this commercial fuel account for work-related purposes, and Claimant was not authorized to use the fuel account to fuel his truck for personal errands or vacation travel. Because of the nature of the business, it was difficult for Employer to monitor whether Claimant used the Employer's commercial gas account strictly for work purposes.

6. During Claimant's employment, the Employer paid for some of the maintenance needs for Claimant's truck. Employer did not pay Claimant's auto insurance.

7. Brady credibly testified that the gas, truck rental fee, and vehicle maintenance were not inducements of employment. Brady indicated that during the two years prior to the date he hired Claimant, Claimant called him frequently, making it clear he wanted to work for the Employer on the Western Slope. Upon being hired, Claimant had the option of using a company truck or using his own truck and being compensated at the rate of $50.00 per day. Claimant elected to use his own truck. Other workers used a company truck. Claimant was not promised that Employer would pay for his gas or

mileage for his travel to Kersey. The evidence establishes that the gas, truck rental fee and vehicle maintenance were not inducements for employment.

8. During Claimant's employment with the Employer, he frequently worked seven days a week, staying full time on the Western Slope. Approximately one weekend per month, Claimant returned to the Front Range for a mandatory meeting with his probation officer, and to visit his family. Claimant would also return to Kersey on holidays.

9. Prior to the date of the accident in question, Claimant told Brady that he planned to take several days off after finishing work on Thursday, April 24, 2008. Claimant indicated that he planned to return to the Front Range to see his probation officer, and to spend time with his family in Kersey. Claimant had a meeting with his probation officer scheduled for the morning of Friday, April 25, 2008.

10. On Thursday, April 24, 2008, Claimant worked for the Employer operating a bull dozer in a reserve pit in northwest Parachute, Colorado. The jobsite in Parachute was located on the Western Slope, about 1½ hours northwest of Battlement Mesa. Claimant worked until approximately 5:00 p.m. After he clocked out, Claimant drove from Parachute south on County Road 215 to the I-70 juncture (Battlement Mesa). Claimant filled up his truck with gas in Battlement Mesa, close to his home. Claimant used Employer's commercial gas account to fill his truck, although he was not authorized to use Employer's gas account to purchase gas to travel to Kersey that day. Claimant then drove east on I-70 from Battlement Mesa towards Denver. Claimant exited I-70 near Denver, taking I-76 northeast towards Greeley. More than 4 ½ hours after leaving work, at approximately 9:45 p.m. on April 24, 2008, Claimant's vehicle was struck by another vehicle causing Claimant to sustain injuries. The accident occurred at milepost 28.5, approximately 30 minutes outside of Greeley.

11. Claimant was not paid for the time he spent driving from Parachute to Battlement Mesa, nor was he paid for driving from Battlement Mesa to Kersey. It is found that Claimant was not within the course and scope of his employment during his drive from Parachute to Kersey. Claimant was not within the course and scope of his employment during the car accident on April 24, 2008.

12. On April 24, 2008, Claimant's travel was after his normal work hours. Claimant was not performing any work duties during his drive to Kersey. Claimant did not confer benefit on the Employer during the drive to Kersey. Claimant's once per month drives to Kersey were not contemplated as part of Claimant's employment with Employer. Claimant's accident did not occur on Employer's premises or work site. Claimant was driving to Kersey for his own benefit: to see his family and to meet with his probation officer during a planned period off of work.

13. The totality of the credible and persuasive evidence presented at hearing causes the ALJ to conclude that Claimant failed to sustain his burden of proof to establish that a compensable work injury occurred on April 24, 2008 in the course and scope of Claimant's employment for the Employer.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the foregoing Conclusion of Law.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Section 8-40-101, *et seq.,* C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving by a preponderance of the evidence that his injury arose out of the course and scope of his employment. Section 8-41-301(1), C.R.S.; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, C.R.S.

2. An injury occurs "in the course of employment" where claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991); *Popovich v. Irlando*, 811 P.2d 379 (Colo. 1991). The "arise out of" requirement is narrower and requires claimant to show a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Id.*

3. Claimant must prove that a causal connection between the injury and his employment exists so that the injury is shown to have its roots in the employee's work-related duties and is so closely related to those functions to be considered a part of the employee's employment contract. *Madden v. Mountain West Fabricators*, 977 P.2d 861, 863 (Colo. 1999), *citing Triad Painting Co. v. Blair*, 812 P.2d 638, 641-42 (Colo. 1991).

4. Claimant's accident did not occur during the course and scope of his employment. Claimant was not coming home from work at the time of his MVA. Claimant was on his way from his work home in Battlement Mesa to his family home in Kersey. Claimant was traveling to Kersey for a long weekend during which he was going to see his probation officer and his family. Claimant lived in Battlement Mesa at the time of his accident. Claimant's drive from Battlement Mesa to Kersey had no ties to his employment with Employer, and therefore did not occur during the course and scope of his employment.

5. Claimant's travel to Kersey was not contemplated by the employment. Travel is contemplated by the employment agreement in the following situations: (a) when a particular journey is assigned or directed by the employer, (b) when the employee's travel is at the employer's express or implied request or when such travel confers a benefit on the employer beyond the sole fact of the employee's arrival at work,

and (c) when travel is singled out for special treatment as an inducement to employment. *Madden, supra at* 885. Here, the competent evidence established that Claimant was not in travel status when he was traveling from the Parachute jobsite to Battlement Mesa, and from Battlement Mesa to the Front Range to see his probation officer and family. Claimant's travel was not assigned or directed by Employer. The travel in question was entirely of Claimant's own volition. Employer did not encourage the trip, it did not request Claimant make the trip, and he had no control over Claimant's travel from the Western Slope to the Front Range, several hours after his job assignment. Claimant's travel from the Western Slope to the Front Range was not expressly or implicitly requested by Employer, and such travel conferred no benefit to Employer.

6. Based on the credible and persuasive evidence presented at hearing, it is found and concluded that Claimant did not suffer a compensable work injury during the car accident of April 24, 2008.

ORDER

It is therefore ordered that:

1. It is concluded that Claimant's claim for workers' compensation benefits for an April 24, 2008 car accident is denied and dismissed.

2. All matters not determined herein are reserved for future determination.

DATED: July 23, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

W.C. No. 4-779-809

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

Hearing in the above-captioned matter was held before Edwin L. Felter, Jr., Administrative Law Judge (ALJ), on July 16, 2009, in Denver, Colorado. The hearing was digitally recorded (reference: 7/16/09, Courtroom 3, beginning at 10:16 AM, and ending at 11:50 AM).

ISSUES

The issues to be determined by this decision concern compensability, and, if compensable, medical benefits (reasonably necessary and authorized).

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant began work for the Employer on May 1, 1995, as a Registered Nurse (RN). Prior to September 29, 2008, Claimant was transferred to a new position called a Patient Care Technician (PCT). The ALJ finds, as noted by Cathy Franca, Claimant's supervising RN, that Claimant was transferred to this new position because she was a good employee and Employer wanted to retain her.

2. On September 29, 2008, Claimant was working as a PCT with a very young patient. Her responsibility included sitting and watching over that patient. According to the Claimant, when the young patient was taken to a procedure, Claimant inquired with a superior concerning any work with which she could help.

3. While helping Liz Tom, a co-worker, Claimant pushed a 450 pound man in a wheelchair from the fifth floor to the elevator and from the elevator to the lobby on the first floor.

4. Claimant experienced no immediate pain following this activity. She alleges that later that evening she experienced a lower back pain that felt "like a knot in her buttocks that radiated down her left leg," as well as a burning sensation.

5. Claimant went to work for her next scheduled shift two to four days later and worked a full duty shift. She completed her last full duty shift on October 12, 2008. The shift entailed administering flu shots and lasted four hours. Cathy Franca did not notice Claimant in any pain during these shifts and she normally saw Claimant once or twice per week.

6. Claimant did not report an injury to her Employer at any of her shifts following September 29, 2008. She did not report the alleged injury because she stated that she felt she might lose her job. Cathy Franca, however, stated that she would expect employees to report work related injuries to her because she had an open door policy and there was no basis for fear of retaliation by Employer.

7. On or about October 13, 2008, Claimant contacted her Employer concerning paid time off and Extended Illness Bank (EIB). Claimant spoke with Arianne Clark, a staffer, and mentioned that she was having back pain but once again Claimant did not report it as a work related injury.

8. On October 14, 2008, Claimant sought medical treatment from Oasis Family Practice, her family doctor's office. On that visit, Claimant complained of pain in her left buttock down to her knee, and she received treatment from Judy Mochizuki, a physician's assistant (PA). Mochizuki diagnosed Claimant with Sciatica. Claimant told Mochizuki that the pain started independently which the ALJ interprets that the pain was not associated with any trauma or event. Claimant also told Mochizuki that the pain started only four days prior to the visit, or on or about October 10, 2008.

9. On October 20, 2008, Claimant sought medical treatment at Oasis Family Practice, from Lynne Kendig, M.D., because of increased back and leg pain. At this visit, Claimant first mentioned that the injury precipitated from lifting patients and pushing heavy objects at work. Claimant noted that the pain started one week prior to this visit, or on or about October 13, 2008. Dr. Kendig ordered an MRI (magnetic resonance imaging) scan, which showed a disc herniation. Claimant was then referred to a neurosurgeon for further evaluation and treatment.

10. On October 29, 2008, Jennifer S. Kang, M.D., evaluated Claimant. Claimant reported continued low left back pain, left lower extremity radicular pain, and a burning sensation in her calf. Once again, Claimant denied any trauma at the initiation of her symptoms, and stated that the pain began on or about October 13, 2008. After discussing various treatment options, Claimant elected to proceed with surgical intervention, which included a left L4-5 semi hemi-laminectomy with disc excision.

11. On November 5, 2008, Claimant went to see Mary Wilkerson, M.D., for a pre-operation physical. Dr. Wilkerson summarily noted that the injury was work related, without further explanation, and that Claimant was excused from work for 4-6 weeks. The ALJ infers and finds that Dr. Wilkerson based her causality opinion exclusively on the history that Claimant gave her.

12. On November 17, 2008, Claimant underwent a decompressive surgical procedure at L4-L5. In a post-operation examination, Dr. Kang referred Claimant for a course of physical therapy for continuing mild low back pain and intermittent discomfort in the left lower extremity.

13. Claimant reported an injury as work related to Arianne Clark, Employer's staffer, on or about November 28, 2008. This report was contrary to the Employer protocol for reporting work related injuries, which generally requires employees to report the injury within 48 hours of the event.

14. Claimant completed and submitted a Workers' Claim for Compensation on December 11, 2008.

15. Dr. Wilkerson's medical opinion was stated as such that Claimant's injury was "irrefutably work related." Based on the lack of an adequate underlying explanation of the basis of this opinion, the ALJ finds it less credible than the opinion of

John S. Hughes, M.D., who is the independent medical examiner (IME), who examined the Claimant at the request of Respondents.

16. Upon a detailed review of Claimant's medical records and a physical examination, Dr. Hughes concluded that Claimant's disc protrusion happened spontaneously and in the absence of precipitating factors or trauma. Additionally, Dr. Hughes noted the discrepancy of the date and event that caused the initial onset of pain according to her medical records. The ALJ finds this discrepancy significant in determining that Claimant's testimony not credible.

Ultimate Findings

17. The Claimant's initial failure to report the injury to the Employer, as well as her failure to attribute the back and leg pain to a specific trauma when she first sought medical treatment from Judy Mochizuki, PA, make it more likely than not that the Claimant's back injury is not work related.

18. As specifically found, Claimant's initial statement tO Mochizuki concerning the date of the onset of back pain is consistent with when Claimant contacted Arianna Clark to request paid time off.

19. Because of the numerous inconsistencies in Claimant's version of events, including the initial date when the pain began, Claimant has failed to prove, by a preponderance of the evidence that she sustained a compensable injury to her back on September 29, 2008.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo.

275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). As found, the Claimant's version of events is inconsistent concerning the time and event that caused her initial back and leg pain. Therefore, as found, the Claimant's testimony is not credible and this lack of credibility undermines her claim for compensability. As found, Dr. Hughes' medical opinion is highly persuasive and credible because it is corroborated by the totality of the circumstances and medical evidence. Dr. Hughes' opinions support the proposition that Claimant did **not** sustain a compensable injury occurring on September 29, 2008, while the she was working for the Employer.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, the Claimant has failed to sustain her burden of proof on compensability.

ORDER

IT IS, THEREFORE, ORDERED THAT:

Any and all claims for workers' compensation benefits are hereby denied and dismissed.

DATED this ____ day of July 2009.

_____
EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-466

ISSUES

I. Did the Claimant prove it is more probably true than not that on January 28,

2009, he suffered an injury arising out of and in the course of his employment when he suffered a torsion (twisting) to his knee while supervising bathroom breaks for his employer?

II. Did the Claimant prove it is more probably true than not that the medical treatment provided by Dr. Marcus Button and Dr. Jacob F. Patterson was reasonable and necessary treatment for the alleged industrial injury?

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at hearing, the ALJ finds the following facts:

1. Southern Peaks Regional Treatment Center is a correctional facility housing youths who have been remanded through the juvenile justice system for correctional treatment and ongoing education.

2. Claimant works as a life skills worker, Level I for the employer and his duties include providing security for the employer by supervising youths who had been committed to the facility. Specific duties for the Claimant include transitioning youth to various activities such as meals, medical services, school, physical education and group activities at their respective dormitories and supervising bathroom breaks.

3. On January 28, 2009, Claimant was supervising the male bathroom breaks for the juveniles at the school building. It is necessary for a staff member to supervise the youths in the bathroom so as to prevent physical confrontations between them and otherwise deter inappropriate behavior. At the time of the incident, the Claimant was supervising up to four youths at a time and was moving the youths in and out of the bathroom in an expeditious manner so as to accommodate all youth for a bathroom break.

4. At hearing, Claimant testified that as he was monitoring the bathroom breaks, the last youth in a group to leave the bathroom suddenly turned on him and challenged him to a physical confrontation by raising his fists and assuming a boxing stance. In response, the Claimant pivoted to his right while reaching out toward the young man, Claimant grabbed him by the shoulders physically turning him and moving him forward out of the bathroom. Simultaneously, the Claimant was asking the young man to move along. In the process of performing this twisting to physically direct the youth out of the bathroom, the Claimant felt two crunching sensations in his left knee and experienced an immediate onset of left knee pain.

5. Claimant did not consider the young man's actions a threat to his safety. Rather, Claimant felt the young man was clowning around and he simply wanted to get him out of the bathroom so that he could accommodate others who were requesting bathroom breaks.

6. Immediately after the incident occurred, Claimant had difficulty walking. Claimant testified that he limped to the administrative office where he reported the incident and his injury to a Robert Young, the supervisor on duty. Claimant was instructed to go home and get care.

7. Claimant immediately followed up with his long-standing chiropractor who documented that on the date in question, Claimant "Twisted his left knee while at work". The chiropractic notes are largely illegible.

8. On January 30, 2009, Claimant was evaluated in the offices of Marcus Button, M.D., Respondents' designated treatment provider. In the January 30, 2009 note, Claimant is noted to have been complaining of "left knee pain x two days, twisted knee at work, heard pop then unable to walk secondary to pain". X-ray of the left knee was recommended and completed.

9. A February 4, 2009 medical record from Dr. Button's office notes that the Claimant presented for follow-up on his left knee and was still complaining of swelling, crepitus and instability. It was recommended that Claimant undergo an MRI.

10. On February 25, 2009, Respondent filed a Notice of Contest denying liability for the claim pending further investigation of medical records. In response, Claimant filed an Application for Expedited Hearing on March 9, 2009.

11. MRI of the left knee was performed on February 25, 2009. The report of the MRI provides a history of "twisting injury, heard cracking sound". The MRI was interpreted by the radiologist as being "difficult and challenging to interpret because

considerable motion artifact". However, according to the radiologist, it was felt that there was a "tear of the medial and posterior horn of the medial meniscus".

12. Dr. Marcus Button opined that the mechanism of injury provided by the Claimant in his verbal history is the type of mechanism that would cause a medial and posterior horn meniscus tear.

13. Claimant had a prior injury to the left knee in 1996 described as a quadriceps tear, which resulted in an arthroscopic procedure to repair the quadriceps tendon. Claimant also suffers from pre-existing left degenerative joint disease in the hip for which Claimant has obtained treatment with Dr. Patterson by referral provided by Dr. Marcus Button's practice. In addition to his consultation with Dr. Patterson for ongoing hip pain, Claimant has obtained chiropractic care for his hip through Arkansas Valley Chiropractic Clinic and Dr. Michael V. Christiansen, D.C.

14. On January 26, 2009, Claimant was evaluated by Dr. Patterson who documented Claimant's left hip pain, which had been improving since about Christmas. According to his January 26, 2009 medical record, Dr. Patterson noted that the Claimant's left hip pain was very severe around Christmas and that he could hardly walk. Dr. Patterson noted that the Claimant was a very large muscular man of 6'6" with a weight of 315 pounds. According to Dr. Patterson's note, "Claimant's weight was appropriate for his height".

15. Prior to the filing of the Application for Hearing, Claimant was re-evaluated in the offices in the Dr. Marcus Button on March 4, 2009 at which time it was documented that Claimant was "injured at work, was assisting a young patient out of the bathroom, twisted knee to turn and felt a pop and immediate pain". According to this note, the Claimant reported the injury to his supervisors and was sent home to receive care. The note reflects that the Claimant was originally evaluated on January 30, 2009, had completed the MRI that was reviewed with Claimant and his wife. According to this note, the MRI "clearly defined a tear of the medial and posterior horn of the medial meniscus, which would be the cause of his pain, and likely occurred at the time of the knee incident at work. I have known this patient for over two years and had provided care for him in another clinic and believe his complaints are legitimate and very true after examining the knee today". The report of March 4, 2009 included a plan documented as a referral to Dr. Jake Patterson for further evaluation, and consideration for surgical intervention. The Claimant's weight on his visit was documented at 320 pounds.

16. On March 11, 2009, Claimant was evaluated by Dr. Patterson who noted that the Claimant's MRI demonstrated meniscus tears which lead Dr. Patterson to the impression that the Claimant had suffered a "acute injury" in the form of a "medial meniscus tear and/or subluxation of the patella superimposed on some pre-existing patella femoral DJD". Dr. Patterson recommended

arthroscopic procedure, which the Claimant was desirous of proceeding forward with.

17. On May 5, 2009, Respondent requested an Independent Medical Examination that was completed by Dr. Eric Riding's. In his report, Dr. Ridings documented the history of this Claimant's injury as follows:

"The patient states that on the day of injury he was monitoring young men who were at a bathroom. One particular young man did not wish to leave and was obstructing the entrance. Mr. Tirk asked him to move along. When he spoke back and did not do so, Mr. Tirk moved toward him gesturing down the hall. As he turned toward the young man (who was approximately 5'6 or 5'7 inches tall) he twisted toward his right while reaching out to touch him, and in the process of doing that twisting movement felt two "crunching" sensations in his left knee and immediate onset of left knee pain. The patient was clear that he did not exert any force on the man but rather felt those painful sensations in the knee as he turned toward him".

18. Claimant was accompanied to the IME by his wife Pamela who was present throughout the Independent Medical Examination. Additionally, Claimant tape recorded the evaluation. Dr. Ridings separately recorded the IME and testified that he maintained a separate copy of the audio recording but had never listened to it. Claimant and his wife dispute the history as documented by Dr. Ridings. Claimant and his wife testified that during the Independent Medical Examination, Claimant demonstrated how he actually made physical contact with the young man in question and although he did not have to exert substantial force to restrain the young man, he did physically turn him while pivoting and directing him toward the door.

19. Dr. Ridings opined that the Claimant likely has meniscal tears of the left knee as interpreted by MRI and that those occurred at the time he twisted his knee. However, Dr. Ridings concluded that the twisting of the knee while speaking to the young man in the bathroom would not be work-related as the incident "could have occurred anywhere". As such, Dr. Ridings reached the conclusion that because Claimant was not engaged in any sort of typical altercation or physical management of this young man that the injury is not work-related.

20. In their Response to Application for Hearing, Respondent asserts that Claimant's condition is not compensable as it constitutes a "idiopathic slip and fall".

21. At hearing, Respondent presented the testimony of Brandon Miller. Mr. Miller works as the program manager in charge of the boys conduct unit for the employer. Mr. Miller testified that the youth in question in this case was part of the conduct program. The program attempts to influence behavior by

rewarding appropriate conduct and penalizing bad behavior. According to Mr. Miller, the youth in the boys conduct unit range in age from 12-16 years old. Occasionally, an older boy of small stature are also part of this unit. Mr. Miller testified he was not on duty at the time of Mr. Tirk's injury.

22. Mr. Miller testified extensively regarding hands on contact between staff members and the boys on the unit. According to Mr. Miller, because many of the kids on the unit have been physically abused, physical contact between staff members and kids can be interpreted by the kids as traumatic. Thus, training surrounding physical contact with the kids on the unit is provided.

23. Mr. Miller testified that any time physical contact is made between a staff member and a child on the unit, documentation in the form of a custody-control incident report is required to be filed. In addition, an interview with the staff member and a debriefing with the youth is required. No such report or interviews exist or have been conducted. Mr. Miller delineated between two types of physical contact, one defined as an "escort" and the other defined as a restraint. Claimant testified that contact consisting of restraints had to be reported, he did not restrain the youth in any fashion he personally did not feel it necessary to do report this as a physical contact. To that extent, Claimant's testimony is consistent with the report of Dr. Eric Ridings when Dr. Ridings documented that Claimant was "not engaged in any sort of typical altercation or physical management of the young man at the time" of this incident.

24. Mr. Miller defined an escort as physical contact between the staff member and the youth where the staff member directs the motion of the kid in question. According to Mr. Miller, the contact between Mr. Tirk and the youthful offender would constitute an escort and Mr. Tirk appeared unaware that escort contact had to be reported. Mr. Tirk testified that he did not feel it necessary to report the physical contact as he did not feel that he was required to do so since the contact did not raise to the level of a restraint.

25. According to Mr. Miller, the actions of the youth in question specifically, turning quickly, confronting a staff member and challenging that staff member to a confrontation would constitute aggressive behavior which would require a separate incident report as the facility does not tolerate aggressive behavior. However, Mr. Miller conceded that the individual involved in the incident has the discretion as to determine what constitutes aggressive behavior and whether such report should be initiated. Claimant testified that he did not consider the youth's behavior aggressive or threatening. Rather, Claimant testified that the youth in question was clowning around, thus did not find the need to report the offender's behavior as aggressive.

26. According to Mr. Miller's testimony, there would be a mandatory process of debriefing the youth following the report of an incident. Mr. Miller testified at hearing that he was unaware of any report that had been filed with

respect to this incident by Mr. Tirk or the supervisor to whom Mr. Tirk reported the incident, Mr. Young. Mr. Young did not testify.

CONCLUSIONS OF LAW

1.The purpose of the Worker's Compensation Act of Colorado (Act), §§8-40-101, et seq., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of evidence is that which leads to the trier-of-fact, after considering all the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo.306, 592 P.2d 792 (1979). The facts in a worker's compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

2.When determining credibility, the fact finder should consider among other things the consistency or inconsistency of a witnesses testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions, the motives of the witness; whether the testimony has been contradicted; and biased, prejudice or interest. See Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A workers' compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. Magnetic Engineering Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

3.Claimant contends that the evidence presented proves that the knee injury he experienced on January 28, 2009 arose out of and in the course of his employment. The Claimant argues that the evidence demonstrates that the Claimant's twisting injury resulting in meniscal tears to the left knee was caused by suddenly pivoting when physically directing the youthful offender from the bathroom. Specifically, Claimant contends that his injury (meniscal tears) has its origin in his work duties. In other words, the injury did not simply arise as an idiopathic condition resulting from the mere act of twisting. But for Claimant's specific requirement to move the kids through the bathroom breaks and his need to physically direct the child in question, this injury would not have occurred.

4.The Claimant must prove by a preponderance of the evidence that his injury was proximately caused by an injury arising out of and in the course of his employment with the employer. Section 8-41-301(1)(b) & (c), C.R.S; see also, City of Boulder v. Streeb, 706 P.2d 786, (Colo. 1985). An injury occurs "in the course of" employment where the Claimant demonstrates that the injury occurred

within the time and place limits of his employment and during an activity that had some connection with his work-related functions. See, Triad Painting Co. v. Blair, 812 P.2d 638 (Colo. 1991). Respondents by the indication of their own IME physician seemly concede that the injury occurred in the course of employment. However, Respondents assert that the injury did not arise out of Claimant's work duties based upon the assertion that the Claimant merely twisted his knee which, in the words of Dr. Ridings, could have occurred anywhere. The assertion ignores the fact that the need to pivot on the knees was caused by Claimant's need to physically direct the young man from the bathroom.

5.The "arising out of" element of the workers' compensation statute is narrower and requires Claimant to show a causal connection between the employment and the injury such that the injury has its origins in and the Claimant's work-related functions and is sufficiently related to those functions to be considered as part of the employment contract. Triad Painting Co., Supra. The mere fact that an injury occurs at work does not establish the requisite causal relationship to demonstrate that the injury arose out of the employment. Finn v. Industrial Commission, 165 Colo. 106, 437 P.2d 542 (1968). In the instant case, the totality of evidence establishes that Claimant's injury arose out of the need to physically direct the youthful offender from the bathroom. The Claimant testified that the actions of pivoting physically grabbing the child and directing him toward the door were all due action. Thus the need to pivot on the knees should not be seen as separate from the necessary actions taken by Claimant to remove this child from the bathroom. Because the actions are not separate, all actions should be seen as being part of Claimant's duties. Thus, the requisite nexus between the Claimant's duties and his injury are satisfied.

6.The ALJ finds Claimant to be credible.

7.Assuming that everything that Mr. Miller testified to is true, it makes little sense for the Claimant to testify in a fashion that would expose him to potential termination from his job or sanctions for perjury leading to particular credibility to Claimant's testimony.

8.If the precipitating cause of an injury at work is a pre-existing health condition that is personal to the Claimant or the cause of an injury is simply is unexplained, the injury does not arise out of the employment unless a "special hazard of the employment combines with the pre-existing condition to contribute to the occurrence of the accident of injuries sustained. Finn v. Industrial Commission, Supra; National Health Laboratories v. Industrial Claim Appeals Office, 844 P.2d 1259 (Colo. App. 1992); Rice v. Dayton Hudson Corp., Workers' Comp number 4-386-678 (ICAO July 29, 1999). This rule is based upon the rationale that unless a special hazard of the employment increases the risk or extent of injury, a fall that is unexplained would do to the Claimant's pre-existing condition lacks sufficient causal relationship to the employment. A "special hazard" is a condition or circumstance that is not generally encountered outside

of the work place. Gates Rubber v. Industrial Commission, 705 P.2d 6 (Colo. App. 2005); Kidwell v. City of Denver, Workers' Compensation number 4-601-057 (ICAO December 15, 2004).

9.In the instant case, it is assumed that Respondent raised Claimant's pre-existing knee injury in 1996 as well as his left hip condition as supporting a theory that the precipitating cause of the Claimant's knee injury was due to a pre-existing health condition resulting in the need for Claimant to assert that a special hazard existed in Claimant's place of employment. Any such argument is misplaced however, as the pre-existing hip condition has no relationship to the Claimant's current meniscal tears and played no role in this injury. Similarly, the Claimant's knee injury in 1996 was of a substantially different nature than that which Claimant is current suffering from. Namely, in 1996, the Claimant suffered a tear of his quadriceps tendon from the knee, which resulted in a quadriceps tendon repair procedure. Therefore, any assertion by Respondent that the precipitating cause of Claimant's current knee injury was a pre-existing health condition is simply unpersuasive. There is no nexus between Claimant's current knee condition and his pre-existing 1996 injury.

10.The question of whether Claimant proved the requisite causal relationship between the injury and the conditions or circumstances of employment is one of fact for determination by the ALJ. Cabela v. Industrial Claim Appeals Office, 198 P.3d 1277 (Colo. App. 2008); Blunt v. Nurse Core Management Services, Workers' Compensation number 4-725-754 (ICAO February 15, 2008). The ALJ concludes that the Claimant proved that it is more probably true than not that he sustained an injury arising out of his employment when he twisted his knee on January 28, 2008. The weight of the evidence establishes that the cause of the Claimant's injury is due to the need to pivot and physically direct a youthful offender from the bathroom, which was the specific duty that Claimant was assigned on the date in question.

11.Claimant's care by Dr. Buttons and Dr. Jacob F. Patterson was reasonable and necessary treatment for the industrial injury and Respondent is responsible for said care.

ORDER

It is therefore ordered that:

1. Claimant's claim for benefits under the Workers' Compensation Act of Colorado is Compensable.

2. Respondent is responsible for all medical care to treat Claimant for his industrial injury to cure or relive him from the effects of said injury.

3. Respondent is responsible for payment of medical care provided by Dr. Buttons and Dr. Patterson to cure or relieve Claimant from the effects of his injury.

4. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. All matters not determined herein are reserved for future determination.

DATE: July 24, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-717-518

ISSUES

Whether the Claimant has proven by a preponderance of the evidence that her alleged tips may be included in calculating her average weekly wage.

FINDINGS OF FACT

1. Claimant is a twenty-three year old woman who worked at the Respondent-employer's place of business located in Salida, Colorado. She worked as a carhop and her job consisted of taking orders from customers and delivering completed orders. She worked at Respondent-Employer's from September 2006 to March 2007 and earned $6.50 per hour.

2. On March 1, 2007, in an admitted work-related accident, Claimant slipped and fell injuring her right knee and face.

3. Respondents assert that Claimant is not entitled to include alleged tips in her average weekly wage because she (1) failed to initially and properly report these tips to the Internal Revenue Service ("IRS"); and (2) the tips she eventually reported (one day before the hearing) were merely unverified estimates and she could not prove she actually received the alleged tips.

4. Claimant initially reported gross earnings of $3,568.79, including $1,100.00 in tips in her 2006 federal income tax return and $1,949.86, including $660.00 in tips, in her 2007 federal income tax return.

5. Claimant asserted she mailed her tax returns, via certified mail, the evening before the hearing hereunder. She admitted belatedly attempting to report her tips in tax returns to the IRS in an attempt to include those tips in her average weekly wage. To explain her actions, she claimed she did not have to file income tax returns because of her low income. She also claimed her employer had no system in place to report tips.

6. Claimant admitted that she never reported the amount of her tips to the Respondent-Employer. She also admittedly guessed at the amount of her tips. She testified she did not keep a daily record of the tips she received. She admitted the Affidavit she signed on the issue was merely a guess. Specifically, the following statement was nothing more than an unverified estimate: "My best day, I earned $110.00. My worst day, I earned about $10.00. I averaged about $20.00 a day in tips at Sonic."

7. Claimant also testified she previously prepared "draft" returns and attached these to her Responses to Interrogatories and these same "draft" returns were not sent to the IRS until the evening before the hearing. She also admitted knowledge that tax returns for the preceding year are due to the federal government in April of the following year.

8. Claimant's mother, Nikki Boyle, testified Claimant had cash when she picked Claimant up from work but admitted she never actually saw Claimant receive tips. She also could not provide any specific testimony regarding the amount of the tips allegedly received.

CONCLUSIONS OF LAW

C.R.S. § 8-4-201(19)(b) provides that for tips to be included in wages, the employee must have reported these tips to the IRS for purposes of filing federal income tax returns. Tips must actually be received and properly reported to the IRS to be considered wages. *Id*. Claimant in this case cannot prove she actually received tips and if so what the correct amount would be.

The plain and ordinary meaning of the wage statute is that gratuities which the Claimant receives in the course of employment may be considered in calculating the average weekly wage, but only if those gratuities were reported to the IRS by the Claimant, or by some other party (such as the employer) on behalf of the Claimant. *In the Matter of the Claim of Brimmerman v. Denny's and CNA Risk Management*, 2000 WL 696879, W. C. No. 4-396-902 (April 5, 2000). The statute permits inclusion of tips in the Claimant's average weekly wage, but also

discourages fraud by requiring documentary and verified evidence tending to corroborate the Claimant's testimony concerning the amount of tips received. *Id*.

This requirement serves to discourage fraud by mandating that the reported tips be tied to an official income tax return rather than a belated, self-serving and unverified communication. *In the Matter of the Claim of Dawit Measho v. Brown Palace Hotel*, 2001 WL 778824, W. C. No. 4-452-636 (June 14, 2001).

Claimant testified she merely guessed at the amount of her tips. She admitted she did not properly account for her tips. She also admitted she only attempted to report these estimated tips to the IRS belatedly so she could hopefully increase her AWW at the hearing. Claimant's actions are exactly what the wage statute and case law attempt to discourage. Specifically, Claimant should not be rewarded for her invalid and belated attempt to report unverified and self-serving tips to increase her average weekly wage.

The statute requires the act of reporting tips must have been completed prior to the time the average weekly wage is calculated. *In the Matter of the Claim of Brimmerman v. Denny's and CNA Risk Management*, 2000 WL 696879. In *Brimmerman*, Claimant testified she did not report tips to the IRS and she had not yet reported her tips at the time of hearing but that she had intended to. *Id*. The Court found the wage statute is worded in the past tense and Claimant's intentions were irrelevant. *Id*. Since the statute is worded in the past tense, the statue "requires that the act of reporting tips must have been completed prior to the time the average weekly wage is calculated." *Id*.

Even if this Court were to accept Claimant's allegation that her tips should be considered reported because she mailed her returns the evening before the hearing, Claimant's returns were not considered filed at the time of the hearing at 9:00 a.m. the following morning.

The Internal Revenue Code requires "returns made on the basis of the calendar year shall be filed on or before the 15th day of April following the close of the calendar year and returns made on the basis of a fiscal year shall be filed on or before the 15th day of the fourth month following the close of the fiscal year." 26 U.S.C. § 6072(a).

If a return is filed outside of the prescribed time, it is not considered filed until actually received by the IRS. 26 U.S.C.A. § 7502(1); see also *Becker v. Dept. of the Treasury/Internal Revenue Serv.*, 823 F.Supp. 231 (S.D.N.Y. 1993).

At the time of hearing, Claimant's returns were not actually filed and under *Brimmeran*, even if the Court were to consider Claimant's alleged tips in calculating AWW, it cannot because the act of reporting tips was not completed prior to the time of calculating AWW.

Perhaps most importantly, Colorado courts have also held that a Claimant is not entitled to include tips in an average weekly wage just because she belatedly reports a tax return to the IRS. *In the Matter of the Claim of Gloris R. Dawes v. Colorado Cabana, Inc.*, 1997 WL 846939, W. C. No. 4-283-730 (August 11, 1997). In other words, a Claimant cannot send in late tax returns with unverified tips and expect her average weekly wage to be increased. *Id*. This is precisely what Claimant did in this case by allegedly submitting unverified tips to the IRS by mail the night before the hearing.

Claimant cannot establish she actually received tips. Claimant's guess as to how much she received in tips is inadequate to establish income for AWW purposes. Indeed, she cannot even recall how much she made on a daily basis because, per her testimony, she did not keep track of her tips. She admitted she merely guessed at the amount of tips she received. She also admitted she only mailed the tax returns in the night before the hearing so that she could hopefully include her estimated tips in her AWW.

Claimant has failed to meet the burden of proof and has not established she actually received tips and properly reported these tips in filed tax returns to the IRS so that the tips may be included in her average weekly wage.

ORDER

It is therefore ordered that:

1. Claimant's claim to have her tips included in her average weekly wage is denied and dismissed.

2. All matters not determined herein are reserved for future determination.

DATE: July 24, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-505-189

ISSUES

1. Whether Claimant's request for medical benefits in the form of a Scheker wrist replacement is barred by the doctrine of issue preclusion.

2. If issue preclusion does not apply, whether Claimant has demonstrated by a preponderance of the evidence that Scheker wrist replacement surgery constitutes authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his industrial injury.

FINDINGS OF FACT

1. On February 7, 2001 Claimant suffered an injury to his left wrist during the course and scope of his employment with Employer. Claimant subsequently underwent numerous procedures to correct his wrist condition. Authorized Treating Physician (ATP) Thomas G. Fry, M.D. performed seven of the surgeries.

2. In approximately November 2007 Claimant experienced a "pop" in his left wrist. After conducting research and considering various options, Dr. Fry recommended a Scheker wrist replacement for Claimant. Dr. Fry explained in his evidentiary deposition that the Scheker wrist device is a prosthetic joint replacement designed to alleviate chronic wrist pain and instability. Dr Fry recommended the device in order to decrease Claimant's pain, improve his wrist function and reduce his medications.

3. At the time of Dr. Fry's recommendation, Claimant was receiving pain management treatment from James Derrisaw, M.D. Dr. Derrisaw recommended a spinal cord stimulator for Claimant in order to reduce his pain, improve function and decrease reliance on narcotic pain medications.

4. Claimant subsequently sought a hearing at the Office of Administrative Courts regarding the Scheker wrist replacement and the spinal cord stimulator. On July 16, 2008 ALJ Jones conducted the hearing. In a Summary Order dated August 18, 2008 ALJ Jones characterized the issues presented at the hearing as follows:

> The issues raised for consideration at the hearing concern medical benefits. Claimant seeks an order, which requires Respondents to authorize a spinal cord stimulator and a Scheker wrist as a reasonable, necessary and related medical benefit.

ALJ Jones concluded that the spinal cord stimulator constituted a reasonable, necessary and related medical benefit. However, she denied Claimant's request for the Scheker wrist procedure because it was not a reasonable and necessary medical benefit. Neither party requested Full Findings of Fact and Conclusions of Law. ALJ Jones' Order thus became final on August 31, 2008.

5. Claimant subsequently obtained the spinal cord stimulator. However, he testified at the present hearing in this matter that the spinal cord stimulator only relieved approximately 5% of his pain and did not reduce his reliance on narcotic pain medication. Based on the continued recommendation

of Dr. Fry, Claimant explained that he would like to undergo the Scheker wrist procedure in order to reduce his pain and improve his function.

6. The issues presented before ALJ Jones and the current matter both require a determination of whether the Scheker wrist procedure constitutes a reasonable and necessary medical benefit as a result of Claimant's February 7, 2001 industrial injury. Respondents contend that Claimant is barred from relitigating the propriety of a Scheker wrist replacement based on the doctrine of issue preclusion. However, Claimant asserts that the issues in the July 16, 2008 hearing and the present matter are not identical because he lacked the same incentive to vigorously litigate the Scheker wrist replacement option at the first hearing. He contends that another treatment modality in the form of a spinal cord stimulator was available at the July 16, 2008 hearing. Claimant now argues that, because the spinal cord stimulator did not relieve his pain, he has a greater incentive to litigate the issue of whether he is entitled to Scheker wrist replacement surgery.

7. ALJ Jones' August 18, 2008 Summary Order is final. Moreover, there is no dispute that there is an identity of parties in both proceedings. Claimant also had a full and fair opportunity to litigate the issue of whether the Scheker wrist procedure was a reasonable and necessary medical benefit before ALJ Jones. Claimant testified at the hearing and presented medical records to support his position. He submitted a position statement and ALJ Jones subsequently issued a Summary Order. The only remaining dispute is whether there is an identity of issues or claims for relief in the proceedings before ALJ Jones and the present matter.

8. Claimant's opening statement at the July 16, 2008 hearing reveals that he sought medical benefits in the form of the spinal cord stimulator recommended by Dr. Derrisaw and the Scheker wrist procedure recommended by Dr. Fry. Although Claimant presented two possible treatment modalities before ALJ Jones, her Summary Order reflects that she permitted the spinal cord stimulator and denied the Scheker wrist procedure. Claimant's current contention that the spinal cord stimulator failed to adequately reduce his pain does not nullify ALJ Jones' determination that he failed to establish that the Scheker wrist device was a reasonable and necessary medical procedure. The issue presented at the current hearing is thus simply a renewed request for the Scheker wrist replacement. A second determination of whether Claimant is entitled to the Scheker wrist device would violate the purpose of issue preclusion in promoting reliance upon and confidence in the judicial system by preventing inconsistent decisions. Because the four criteria for the doctrine of issue preclusion have been satisfied, Claimant is barred from relitigating whether a Scheker wrist replacement constitutes a reasonable and necessary medical procedure.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Although the principles of issue or claim preclusion were developed in the context of judicial proceedings, the doctrines are applicable in workers' compensation matters. *Sunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44 (Colo. 2001). Issue preclusion is an equitable doctrine that bars relitigation of an issue that has been finally decided by a court in a prior action. *Bebo Construction Co. v. Mattox & O'Brien*, 990 P.2d 78, 84 (Colo. 1999). The purpose of the doctrine is to relieve parties of the burden of multiple lawsuits, to conserve judicial resources, and to promote reliance upon and confidence in the judicial system by preventing inconsistent decisions. *Id.* Issue preclusion operates to bar the relitigation of matters that have already been decided as well as matters that could have been raised in prior proceedings. *Argus Real Estate, Inc. v. E-470 Pub. Highway Auth.,* 109 P.3d 604 (Colo. 2005). The doctrine prevents relitigation of an issue when the following apply: "(1) the issue sought to be precluded is identical to an issue actually determined in the prior proceedings; (2) the party against whom estoppel is asserted has been a party to or is in privity with a party to the prior proceeding; (3) there is a final judgment on the merits in the prior proceeding; and (4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding." *Sunny Acres Villa, Inc.*, 25 P.3d at 47; *In Re Lockhart*, W.C. No. 4-725-760 (ICAP, May 21, 2009).

5. As found, the issues presented before ALJ Jones and the current matter both require a determination of whether the Scheker wrist procedure constitutes a reasonable and necessary medical benefit as a result of Claimant's February 7, 2001 industrial injury. Respondents contend that Claimant is barred from relitigating the propriety of a Scheker wrist replacement based on the doctrine of issue preclusion. However, Claimant asserts that the issues in the July 16, 2008 hearing and the present matter are not identical because he lacked the same incentive to vigorously litigate the Scheker wrist replacement option at the first hearing. He contends that another treatment modality in the form of a spinal cord stimulator was available at the July 16, 2008 hearing. Claimant now argues that, because the spinal cord stimulator did not relieve his pain, he has a greater incentive to litigate the issue of whether he is entitled to Scheker wrist replacement surgery.

6. As found, ALJ Jones' August 18, 2008 Summary Order is final. Moreover, there is no dispute that there is an identity of parties in both proceedings. Claimant also had a full and fair opportunity to litigate the issue of whether the Scheker wrist procedure was a reasonable and necessary medical benefit before ALJ Jones. Claimant testified at the hearing and presented medical records to support his position. He submitted a position statement and ALJ Jones subsequently issued a Summary Order. The only remaining dispute is whether there is an identity of issues or claims for relief in the proceedings before ALJ Jones and the present matter.

7. In assessing whether there is an identity of claims for relief, the inquiry is not focused on the specific claim or the legal theory asserted. *Holnam,* 159 P.3d at 798. Rather, the key inquiry involves the injury for which relief is sought. *Id.* Claim or issue preclusion prevents a litigant from splitting claims into separate actions because, once a judgment is entered, the claimant's claim is extinguished. *Id.* Claim preclusion thus bars relitigation not only of claims actually decided but of all claims that might have been decided if the claims are connected by the same injury. *Id.*

8. As found, Claimant's opening statement at the July 16, 2008 hearing reveals that he sought medical benefits in the form of the spinal cord stimulator recommended by Dr. Derrisaw and the Scheker wrist procedure recommended by Dr. Fry. Although Claimant presented two possible treatment modalities before ALJ Jones, her Summary Order reflects that she permitted the spinal cord stimulator and denied the Scheker wrist procedure. Claimant's current contention that the spinal cord stimulator failed to adequately reduce his pain does not nullify ALJ Jones' determination that he failed to establish that the Scheker wrist device was a reasonable and necessary medical procedure. The issue presented at the current hearing is thus simply a renewed request for the Scheker wrist replacement. A second determination of whether Claimant is entitled to the Scheker wrist device would violate the purpose of issue preclusion

in promoting reliance upon and confidence in the judicial system by preventing inconsistent decisions. Because the four criteria for the doctrine of issue preclusion have been satisfied, Claimant is barred from relitigating whether a Scheker wrist replacement constitutes a reasonable and necessary medical procedure.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for a Scheker wrist replacement is denied and dismissed.

DATED: July 27, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-703-206

ISSUES

The issue before the Court is whether Claimant is entitled to permanent total disability benefits as a result of the admitted compensable injury suffered by Claimant on September 27, 2006 while working for JE Dunn Construction.

FINDINGS OF FACT

1. The ALJ finds Claimant's objection to the late filing of legal authority to be without merit and the ALJ will consider same in the outcome of this case.
2. The ALJ finds the legal authority cited neither persuasive nor binding.
3. Claimant suffered a compensable work-related injury while working for the Respondent-Employer on September 27, 2006. Claimant's date of birth is May 10, 1973. Claimant reached maximum medical improvement on November 1, 2007.
4. Claimant sought and received medical care at Concentra Medical Facility as well as from Katharine Leppard, MD. Dr. Leppard has reported and testified that Claimant suffers a right L5-S1 lateral disc herniation along

with depression as a result of this injury. Dr. Leppard provided Claimant with medication for depression along with analgesic narcotic medication for Claimant's injury related pain. Dr. Leppard referred Claimant to Dr. Jose Vega, Ph.D., who diagnosed Claimant with major depression single episode as a result of this compensable accident. Dr. Leppard and Dr. Vega both reported that Claimant's psychiatric issues are secondary to this compensable claim.

5. Dr. Leppard testified that as a result of his compensable injury Claimant should be restricted to lifting no more than ten pounds and should alternate sitting and standing at will. In support of her opinion that Claimant suffers a right L5-S1 lateral disc herniation, Dr. Leppard notes that on April 10, 2007 Claimant had a right L5 selective epidural injection with good results that lasted approximately fifteen days. Dr. Jeffery Jenks performed that injection.

6. Dr. Leppard testified that the fifteen-day period of relief that Claimant experienced as a result of the epidural injection constitutes reliable corroborative evidence supporting her diagnosis of a right L5-S1 lateral disc herniation. Dr. Leppard also testified that she personally reviewed the MRI films taken of Claimant's low back that show the L5-S1 herniation that the reviewing radiologist reported in this matter *as* being consistent with a determination of L5-S1 herniation. Dr. Leppard is board certified in physical medicine, electrodiagnostic medicine, neuromuscular medicine and pain medicine. She is level II with the Division of Workers' Compensation and is skilled in the review of MRI images.

7. Dr. Leppard testified that approximately fifteen percent of her practice made up of evaluating and treating work injured claimants and that she frequently sees patients with problems similar to the ones suffered by Claimant.

8. Dr. Leppard saw the Claimant in treatment ten times prior to giving her testimony on May 4, 2009. At time of hearing Dr. Leppard testified that it would be her opinion that Claimant would likely have to change positions approximately every fifteen minutes,

9. Dr. Leppard testified consistent with the opinions rendered by both Mr. Fitzgibbons and Ms. Ferris that Claimant's pain behavior would make it very difficult and likely not possible for Claimant to obtain employment with any prospective employer. The balance of Dr. Leppard's testimony reasonably rules out Claimant's return to any type of manual labor and given her restrictions imposed on Claimant's return to work, it is unanimously agreed by Mr. Fitzgibbons, Ms. Fenis and Dr. Leppard that Claimant would be unable to maintain employment. Moreover, Dr. Leppard testified that given the nature of Claimant's herniated disc, Claimant should be protected and restricted from returning to manual labor because with a lateral disc herniation and chronic pain, Claimant would be at high risk for re-injuring himself.

10. Respondents' medical witness Dr. Allison Fall testified at evidentiary deposition. She testified that she did not use worksheets to determine Claimant's mental impairment, did not have worksheets to show that she performed or measured Claimant's loss of range of motion of his back and further testified that although she did not know what Claimant did in his job as a laborer, he could nevertheless return to his construction job in spite of his injury. Dr. Fall has board certification in physical medicine and physical rehabilitation.

11. The administrative law judge finds that Dr. Leppard is persuasively qualified and more knowledgeable as to the clinical status of Claimant. The administrative law judge notes that there is insufficient record support to show that Dr. Fall read or reviewed the MRI films as did Dr. Leppard and there is insufficient evidence to show that Dr. Fall has training or competency to review MRI films.

12. Claimant's education consists of five years of primary school in Mexico. He understands some words in English and when tested demonstrated a first grade reading level in English, third grade level in arithmetic. Claimant has no computer experience and is unable to type. Both of the vocational experts in this matter testified that if Dr. Leppard's restrictions and opinions are adopted in determining Claimant's ability to return to work or maintain employment, Claimant in fact has been rendered unemployable and unable to earn a wage as result of the injury sustained in this compensable claim.

13. The ALJ finds the medical opinions of Dr. Leppard to be the most persuasive and credible medical evidence.

14. The ALJ concludes that the opinions rendered by the vocational experts is consistent, that if Dr. Leppard’s opinions are given the greater weight, that the Claimant is permanently and totally disabled as he is unable to earn a wage at his former or any employment.

15. The ALJ concludes that the Claimant is permanently and totally disabled as a result of his work-related injury with the Respondent-Employer.

16. WHEREFORE the administrative law judge issues the following:

CONCLUSIONS OF LAW

The ALJ concludes Claimant’s objection to the Respondents’ late filing of legal authority to be without merit and the ALJ will consider same in the outcome of this case.

The ALJ finds the legal authority cited neither persuasive nor binding.

To prove his claim that he is permanently and totally disabled, Claimant shoulders the burden of proving by a preponderance of the evidence that he is unable to earn any wages in the same or other employment. Sections 8-40-201

(16.5)(a) and 8-43-201, C.R.S. (2003); *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The facts in a workers' compensation case may not be interpreted liberally in favor of either claimant or respondents. Section 8-43-201, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

The term "any wages" means more than zero wages. *See Lobb v. Industrial Claim Appeals Office,* 948 P.2d 115 (Colo. App. 1997); *McKinney v. Industrial Claim Appeals Office,* 894 P.2d 42 (Colo. App. 1995). In weighing whether Claimant is able to earn any wages, the ALJ may consider various human factors, including claimant's physical condition, mental ability, age, employment history, education, and availability of work that the Claimant could perform. *Weld County School Dist. Re-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). The critical test is whether employment exists that is reasonably available to Claimant under his or her particular circumstances. *Weld County School Dist. Re-12 v. Bymer*, *supra*.

As a matter of public policy, PTD benefits may be awarded even if claimant holds some type of post-injury employment where the evidence shows that claimant is not physically able to sustain the post-injury employment, or that such employment is unlikely to become available to claimant in future in view of the particular circumstances. *Joslins Dry Goods Co. v. Industrial Claim Appeals Office*, 21 P.3d 866 (Colo. App. 2001).

The ALJ adopts and prefers the opinions expressed by Dr. Leppard over those expressed by Dr. Fall and therefore, when considering those opinions, the two vocational experts along with the relevant criteria for determining disability as stated above, it is concluded that Claimant has in fact been rendered permanently and totally disabled as a result of the injuries sustained in this compensable accident.

Respondents shall to pay Claimant permanent total disability benefits for the remainder of Claimant’s life or as otherwise terminated by operation of law. Respondents have filed a final admission that admits for Grover medical benefits.

WHEREFORE the ALJ issues the following:

ORDER

It is therefore ordered that:

1. The Respondents shall pay permanent and total disability benefits to Claimant in accordance with the Workers’ Compensation Act of Colorado.

2. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

3. All matters not determined herein are reserved for future determination.

DATE: July 27, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-545-531

ISSUES

The issues presented for adjudication are: 1) Did Claimant suffer a compensable injury on June 25, 2002?; 2) If an incident occurred, is that incident the cause of Claimant's current medical treatment and disability?; and 3) Is Claimant permanently totally disabled as a result of the June 25, 2002, incident?

FINDINGS OF FACT

Pre-Injury

1. In June of 1986, Claimant graduated from high school with a G.P.A. of 1.27. He ranked 117 out of 122 in his graduating class. Claimant attended a community college in the fall 1986 and was given failing grades for that semester. Although Claimant indicated he attended Rutgers University, Rutgers has no record of Claimant.

2. In January1987, Claimant had a motor vehicle accident where he ran into a tree. His head hit the windshield and he lost consciousness. He was transported to the emergency room. A CT scan of his head revealed a tumor. A craniotomy was performed to remove the tumor. After the surgery, Claimant developed epilepsy (seizure disorder), migraine headaches and depression. He continued to develop seizures, which remained uncontrolled secondary to Claimant's failure to take his prescribed medication.

3. Claimant obtained employment despite his migraines, uncontrolled seizures, and depression. He could not keep any job for an extended period of time and was terminated from or abandoned many of his positions. In the three years before the accident, Claimant worked at Chipotle, Z-Teca,

Armadillo, Boondocks Fun Center, and ADT Security. The average length of time at each employer was less than four months.

4. As Claimant's employment became more sporadic, Claimant began having work injuries, several of which involved claimed head injuries. On June 17, 2000, Claimant fell out of chair at work and hit his head on the floor and lost consciousness. Claimant had been non-compliant with his seizure medications. Claimant had a long history of migraines. Claimant was taking prescription medications for those migraines. Claimant experienced stress and anxiety.

5. On March 26, 2001, Claimant fell fifteen feet through a false ceiling and landed on a table. Claimant hit his head in the fall and was diagnosed with a concussion. He subsequently reported an aggravation of his seizures and migraine headaches as a result of that accident.

6. On November 16, 2001, seven months before the alleged injury in this case, Claimant had a seizure while at work. He fell, injuring his head. Again it was noted that Claimant was not compliant in taking his seizure medications and Claimant reported headaches and nausea.

7. Claimant demonstrated difficulties with social functioning prior to June 25, 2002, as established by his custody dispute with his ex-wife resulting from his June 2001 divorce. His then-girlfriend, now his wife, filed a permanent restraining order against Claimant in January 2002.

8. Claimant had significant pre-existing medical problems including a seizure disorder, headaches, anxiety, depression and personality disorders prior to the injury in this claim. These physical conditions required medications and medical treatment and mental conditions affected Claimant's employment and social functioning.

Injury

9. On June 25, 2002, in the course and scope of his employment, a jar of pickles fell on Claimant's head. Claimant was not particularly concerned about his symptoms and continued to work for a few more hours. Claimant did not seek immediate medical attention.

10. Two days later, at the insistence of Employer, Claimant reported to Dr. Seimer and complained of nausea and headaches. Claimant appeared alert and in no acute distress. Claimant had a contusion to his head and suffered a mild closed head injury and a concussion.

11.Claimant had evaluations to rule out significant injuries. An MRI of the head was taken on July 1, 2002, which showed evidence of an old craniotomy but was otherwise unremarkable and did not reveal any new abnormalities.

12.Dr. Seimer referred Claimant to a neurologist, Dr. Hammerberg, for evaluation. In August 2002, Claimant reported to Dr. Hammerberg. Claimant's mental status and cognition was intact and his speech was normal. Dr. Hammerberg's report did not reflect any cognitive deficits.

13.By July 9, 2002, Dr. Seimer released Claimant to full duty. Claimant did have further evaluations, including an MRI and neurological evaluation by Dr. Hammerberg. These evaluations failed to detect cognitive deficits or any new brain damage.

14.Claimant continued to work for Employer as a restaurant manager until January 2003, seven months after the accident.

15.On February 28, 2003, Claimant was hired by Intown Suites as a property manager. Claimant could perform the essential functions of the job and Claimant had no physical limitations that prohibited him from working as a property manager. Claimant completed an employment application and signed various authorizations, had training in office procedures and reviewed office manuals. His employer rated his quality of work productivity, ability to work with others, and punctuality, as good. He successfully worked as a property manager until May 15, 2003. Claimant also was employed at a restaurant in January 2004.

16.Claimant did not receive any medical care or treatment for a work-related problem from September 2002 until December 2003. Claimant was examined by Dr. Mechanic and Dr. Kutz, but no treatment was rendered.

17.By May 2003, Claimant had been treated by Dr. Seimer, had an MRI of his brain, and a neurologic evaluation by Dr. Hammerberg. He was released to full duty by Dr. Seimer and returned to work at Employer. Claimant worked for employer for seven months and then obtained another job at Intown Suites. He told Intown Suites he could perform all the functions of the job without accommodation and without limitations. Before May 2003, Claimant had not received medical care for about ten months and had been successfully employed with two employers. Claimant's work-related disability and functional problems resolved and no additional medical treatment was necessary for his work-related injury.

Post Injury

18.In December 2003, over a year and half after the injury, Claimant presented to Dr. Woodcock with numerous complaints including migraines,

seizures, cognitive problems, depression, and a right shoulder injury. Dr. Woodcock diagnosed Claimant with suffering from post-concussive syndrome with cognitive impairment. Dr. Woodcock treated Claimant six to twelve times per year until January 2009. The severity of Claimant's subjective complaints increased despite that treatment,

19. Claimant began to treat with Dr. Grenhart for his psychological issues, including depression, anxiety, and his personality disorder, in June 2005. Claimant continues to complain of these problems today despite approximately 47 visits with Dr. Grenhart. Some of Dr. Grenhart's sessions involved Claimant discussing personal issues such as his divorce, his issues with women, his issues with his children and issues with litigation stress with his workers compensation claim and his divorce proceedings.

20.Today, Claimant subjectively complains of depression, anxiety, paranoia, stress, personality dysfunction, seizures and migraines.

21.Claimant is going through a protracted legal battle with his ex-wife. Claimant's current condition is similar to his pre-accident condition.

Cognitive Deficits

22.Claimant did not suffer any cognitive deficits as a result of the work injury. Dr. Moe, Dr. Bernton and Dr. Quintero's opinions that Claimant's current cognitive deficits and migraine headaches are not related to the June 25, 2002, accident are credible and persuasive.

23.Claimant's initial complaints resulting from the June 25, 2002, injury including the headaches and vomiting, resolved and Claimant's current complaints are not a result of the June 25, 2002, injury. Closed head injuries from traumatic events appear worse within 24 to 48 hours after the event and get better with time. Therefore, Claimant's complaints from the June 25, 2002, would have been at their worst when Claimant presented to Dr. Seimer's office for treatment. Claimant initially presented with virtually no cognitive impairment. Dr. Bernton, Dr. Moe and Dr. Woodcock all testified that Claimant's initial treatment records from Dr. Seimer and Dr. Hammerberg did not show cognitive deficits. However, as time progressed, Claimant's complaints of cognitive deficits increased in severity. Dr. Bernton, Dr. Moe and Dr. Quintero's opinions that the June 25, 2002, accident did not cause Claimant's current cognitive deficits are persuasive.

24.Claimant's symptoms from the work-related mild closed head injury resolved within a couple of weeks of the injury or by May 2003. By that time, Claimant had been treated by Dr. Seimer and Dr. Hammerberg and was found to have no cognitive deficits. Claimant stopped seeking treatment for his work injuries by September 2002. Claimant remained employed as a restaurant manager at Steak Escape until January 2003. After that time, Claimant applied for and was hired to fill a property manager position with Intown Suites from February 2003 until May 2003. Claimant was functioning at his baseline at least as of May 2003.

25.Claimant's current cognitive impairment is pre-existing and not a result of the June 25, 2002, accident. Claimant had several head injuries predating the accident and had brain surgery in 1987 to remove a tumor. Claimant did poorly in high school and couldn't successfully complete one semester of community college. His work history was sporadic. In the three years before the work injury, Claimant was employed at five different employers for an average of four months each. He was fired from three of these jobs, quit once, and just stopped showing up to the other job. Claimant's pre-existing cognitive impairment was aggravated by the litigation stress he experiences as a result of this litigation and litigation with his ex-wife.

26.Dr. Woodcock's testimony that Claimant's cognitive defects are a result of the June 25, 2002, injury is not persuasive. At the time Dr. Woodcock came to his opinions as to the June 25, 2002, injury, eighteen months had passed since the initial accident and he had no prior medical records relating to

Claimant's prior head injuries, his previous craniotomy, his previous seizure disorder, or his previous migraine complaints. He also did not possess records relating to Claimant's initial treatment, employment records or education records. Dr. Woodcock based his opinion significantly on Claimant's own report of the accident, which the Judge finds unreliable and not credible.

27.The Judge credits the opinions and reports of Dr. Moe, Dr. Bernton and Dr. Quintero that Claimant suffered a contusion and mild closed head injury on June 25, 2002, and that symptoms from this injury had resolved by May 2003. To the extent other evidence suggests that Claimant experienced cognitive deficits as a result of the June 25, 2002, work injury, that evidence is rejected as incredible and unpersuasive.

Psychological problems

28.Claimant had pre-existing personality dysfunction, paranoia and anxiety. Claimant had depression and anxiety after the 1987 craniotomy. These problems affected Claimant's capacity to maintain employment and interpersonal relationships. Claimant's job history indicted that Claimant would present well with reasonable communication skills, allowing him to secure jobs in sales/restaurant management positions. However, as employment continued, Claimant began to experience performance difficulties in maintaining that employment.

29.The Judge credits Dr. Zierk's testimony that Claimant demonstrated pre-existing maladaptive coping skills inherent in stressful situations, and personality characteristics that become flared or present during times of high stress situations with paranoid features that predate the alleged injury. Dr. Moe also testified that Claimant had preexisting personality dysfunction and maladaptive personality traits. The Judge finds Dr. Zierk and Dr. Moe's opinions in this regard persuasive. To the extent any other parts of Dr. Zierk's testimony could be construed in support of the assertion that Claimant's current complaints are related to the June 25, 2002, accident, that testimony is rejected as unpersuasive.

30.Dr. Moe testified that the stress of litigation caused Claimant's cognitive and psychological symptoms. Dr. Grenhart also testified that litigation stress from this litigation and his litigation with his ex-wife regarding custody issues aggravates Claimant's psychological condition. Dr. Woodcock testified that Claimant's stress from handling legal and financial matters has resulted in increased emotional and physical symptoms, including seizures. As a result, Claimant's current psychological problems are the result of his pre-existing conditions and aggravated by litigation stress, not a result of the June 25, 2002, accident. To the extent any of the rest of Dr. Woodcock's and Dr. Grenhart's testimony could be construed in support of the assertion that

Claimant's current psychological complaints are related to the June 25, 2002, accident, that testimony is rejected as unpersuasive.

31.Dr. Grenhart and Dr. Woodcock testified that Claimant's current psychological condition, including anxiety, depression, and paranoia, is related to the June 25, 2002, accident. These opinions are not credited because neither doctor had complete medical records relating to Claimant's prior head injuries, his previous craniotomy, his previous seizure disorder, his previous migraine complaints, or his pre-existing depression. Neither Dr. Grenhart nor Dr. Woodcock possessed Claimant's initial treatment records, academic records, employment records, or other social records. Both relied heavily on Claimant's self report, which the Judge finds to be not credible. To the extent other evidence suggests that Claimant experienced psychological symptoms as a result of the June 25, 2002, work injury, the Judge finds that evidence unpersuasive.

Seizures

32.Claimant's current seizures are the result of his pre-existing seizure disorder, not the June 25, 2002, injury. Claimant began experiencing seizures after a left parietal bone tumor was removed and a plate was inserted his head. Claimant carried a diagnosis of epilepsy and repetitive seizures. Claimant had prescriptions for anti-seizure medications but has a history of being non-compliant with taking those seizure medications. Since that time, Claimant experiences uncontrolled seizures.

33.The Judge credits the opinions of Dr. Moe, Dr. Bernton and Dr. Quintero that Claimant's current seizures are not a result of the June 25, 2002, accident but are pre-existing. Claimant experienced seizures before June 25, 2002, incident, including the following documented seizures: three seizures on June 17, 2000, a seizure two weeks after a March 2001 fall, a seizure in October 2001 and yet another seizure on November 16, 2001.

34.Claimant's seizures have not significantly increased since the June 25, 2002, accident. To the extent that Claimant experienced an increase in seizures, any increase was temporary and Claimant has now returned to his baseline pre-existing state. The Judge finds that Claimant's current seizures are pre-existing and not related to the June 25, 2002, accident. The Judge does not find the reports or opinions of Dr. Woodcock persuasive. The reports and testimony of Claimant and Claimant's wife are not persuasive with respect to Claimant's seizures.

Shoulder

35.Claimant reported repeated dislocations of his right shoulder while having seizures in December 2003. Claimant did not report any shoulder

problems before December 2003 to his medical providers. To the extent any of Claimant's evidence suggests, the shoulder injury occurred prior to May 2003, that evidence is not credible or persuasive.

36. MRIs taken of shoulder revealed degenerative changes. Claimant underwent a right shoulder surgery with Dr. Boublik on April 8, 2008.

37.Claimant's complaints as a result of the June 25, 2002, incident had completely resolved by May 2003, and the right shoulder injury is not related to the June 2002 accident. Any potential shoulder problems manifested themselves after the work condition had resolved. The Judge credits the opinion of Drs. Moe, Bernton and Quintero, that Claimant's work-related conditions resolved by May 2003.

38.Dr. Bernton's testimony that Claimant's right shoulder injury is not related to the June 25, 2002, accident is credible. MRIs taken of Claimant's right shoulder do not evidence any dislocations as reported by Claimant. Additionally, Dr. Bernton opined that MRIs of the right shoulder demonstrate degenerative changes, not findings due to any specific injury or injuries during a seizure. Therefore, Claimant's shoulder injury is not related to the June 25, 2002, injury. As to the claimed shoulder injury, the Judge credits the opinions of Dr. Bernton that such injury is not work-related.

39.The Judge finds Dr. Boublik's testimony that the Claimant's right shoulder injury is related to the June 25, 2002, is not persuasive. Claimant reports that this injury was caused by dislocations during seizures. However, the Judge finds that Claimant's seizure disorder is pre-existing and the increase of seizures, if any, resolved by the time the shoulder problems began. Dr. Boublik's opinion as to the cause of Claimant's shoulder complaint is untrustworthy because it is based mostly on Claimant's self report history, which the Judge finds unreliable. Dr. Boublik had no knowledge as to Claimant's pre-existing seizure disorder. Dr. Boublik admits that the Claimant's right shoulder injury could have been caused by any number of events. The Judge finds Dr. Boublik's testimony unpersuasive. To the extent other testimony or reports suggest Claimant shoulder injury is traceable to the work injury, those reports and testimony are rejected as unpersuasive.

40.Claimant failed to prove his shoulder injury is a compensable injury related to the June 2002 accident. Claimant's shoulder problems are not directly the result of the June 25, 2002, incident nor are they traceable though a chain of causation to the June 25, 2002, incident. Claimant's shoulder problems are degenerative and were not altered by the work related incident.

Ongoing Medical Care

41.Claimant's current medical care is not related to the June 25, 2002, injury. Claimant's work-related conditions resolved by May 2003 and no further medical care of any kind was warranted. The June 25, 2002, injury did not cause any of Claimant's medical care, treatment or medications after May 2003.

42.The opinions of Dr. Moe, Dr. Bernton and Dr. Quintero that whatever medications Claimant needs for his seizure disorder, cognitive impairment, migraine headaches, psychological problems and shoulder injury are made necessary by preexisting factors or the later development of non-injury related psychiatric symptoms are credible and persuasive. None of the medications are used to treat the effects of the June 25, 2002, injury. Claimant has failed to prove entitlement to these medical benefits.

43.The Judge credits the opinions of Dr. Moe, Dr. Bernton and Dr. Quintero that Claimant no longer needs further medical care of any kind as a result of the June 25, 2002, accident. Dr. Woodcocks and Dr. Grenhart's testimony and reports are not credited in this regard. To the extent other evidence suggests Claimant needs further care for the work related injury, that evidence is not persuasive or credible.

Permanent Total Disability Benefits

44.The June 25, 2002, injury did not cause or significantly contribute to the Claimant's inability to earn wages. Claimant has fully recovered from the compensable injury of June 25, 2002, and any inability to earn wages is not a result of the June 25, 2002, injury. Claimant is not permanently and totally disabled as a result of the compensable injury.

45.Claimant is able to work even assuming Claimant's current conditions are a result of the June 25, 2002, injury. The testimony of Dr. Moe, Dr. Bernton and Dr. Quintero establish Claimant is capable of earning wages in some type of employment. Dr. Zierk also testified that, based on medical opinions of Dr. Moe, Dr. Quintero and Dr. Bernton, Claimant has the capacity to return to work. In this very limited regard, the Judge credits Dr. Zierk's opinion. Dr. Zierk's other opinions are not persuasive.

46.Claimant was successfully employed with three different employers after the June 25, 2002, accident. Claimant continued to work for employer for seven months post-accident and applied for and was hired by Intown Suites as a property manager, working there for three months. Claimant also worked at a restaurant in 2004.

47. Claimant has the functional capacity to be employed. After the June 25, 2002, accident, Claimant got married and fathered two children, who he independently supervises. He plays basketball, jogs, lifts weights, and even

coaches the neighborhood kids in basketball. He took on his ex-wife in a protracted custody battle in which he sought responsibility in caring for his older children. Claimant continues to drive an automobile.

48.Claimant is employable in the same or other employment. Claimant has the ability to work part-time. Mr. Macurak's testimony that there are jobs available for occupations that fall within Claimant's current demonstrated skills and abilities is persuasive.

CONCLUSIONS OF LAW

1. Compensability

Claimant bears the burden to prove by preponderance of the evidence that he sustained an injury arising out of the course of his employment. City of Boulder v. Streeb, 706 P.2d 786, 789 (Colo. 1985); §8-41-301, C.R.S. (2008). The preponderance of the evidence standard is met when "the existence of a fact is more probable than it is non-existence." Industrial Commission v. Jones, 688 P. 2d 1116, 1119 (Colo. 1984).

To prove compensability, a Claimant must demonstrate an "accident" and resulting "injury." The term accident refers to an "unexpected, unusual or undersigned occurrence." C.R.S. § 8-40-201(1) (2008). In contrast, an "injury" refers to the physical trauma caused by the accident. An "accident" is the cause of and an "injury" is the result. City of Boulder v. Payne, 426 P.2d 194 (Colo. 1967). No benefits flow to the victim of an industrial accident unless an "accident" results in a compensable "injury." All other "accidents" are not compensable injuries. Ramirez v. Safeway Steel Prods. Inc., W.C. No. 4-538-161 (ICAO, Sept. 16, 2003).

The Judge is persuaded by the reports of Dr. Seimer that Claimant sustained a compensable injury as a result of the June 25, 2002, accident, including a contusion to the head and a mild closed head injury or post concussive syndrome. Any additional claimed injuries, including injury to the neck, knees, or shoulders, are not compensable as they are not related to or caused by the June 25, 2002, accident.

2. Medical Care

Claimant bears the burden to prove he is entitled to reasonable and necessary medical care. C.R.S. §8-42-101(1)(a) (2008). Claimant also must prove a causal relationship between the industrial injury and the medical treatment for which he seeks benefits. Snyder v. Indus. Claim Appeals Office, 942 P.2d 1337 (Colo.App. 1997). Medical benefits are available to cure or relieve the effects of the industrial injury. Insurer must also provide care when necessary to maintain or prevent the deterioration of the work related condition. Regardless of whether the care is curative or maintenance in its nature, the Judge concludes that Claimant has failed to prove care or treatment of any nature is a result of the work injury after May 2003.

In this case, the Judge finds that Claimant has recovered from effects of the June 25, 2002, accident. Claimant failed to prove that any of his current medical care and treatment is a result of the June 25, 2002, accident. The care for which Claimant seeks is related to pre-existing or unrelated medical conditions and not the work injury.

3. Permanent Total Disability Benefits

To be totally disabled, Claimant must demonstrate he is unable to work in the same or other employment. C.R.S. § 8-40-201(16.5). The Judge must consider "human factors" including the Claimant's physical condition, mental ability, age, employment history, education and "availability of work" the Claimant can perform. Christie v. Coors Transportation Co., 933 P.2d 1330 (Colo. 1997); Weld County Sch. Dist. RE-12 v. Bymer, 955 P.2d 550 (Colo. 1998).

Considering all of these factors, Claimant remains capable of earning wages in the same or other employment. The Judge is persuaded by the testimony of Dr. Moe and Dr. Bernton that Claimant has no restrictions that would prevent him from working. The Judge is also persuaded that Claimant is able to be employed because Claimant obtained and worked at multiple employers after his injury, engaged in sports and other activities demonstrating physical and mental capabilities to be employed, has the skills to obtain additional employment, and there are jobs available to Claimant.

To be entitled to permanent total disability benefits, Claimant must demonstrate that the industrial injury was a significant causative factor in the Claimant's permanent total disability in that it must bear a direct causal relationship between the precipitating event and the resulting disability. Seifried v. Indus. Comm'n, 736 P.2d 1262 (Colo. Ct. App. 1986); Cooper v. ICAO, 998 P.2d 5 (Colo. App. 1999) *aff'd* 25 P.3d 44 (Colo. 2001). To the extent any evidence suggests Claimant is incapable of employment, those factors predated the injury. To the extent there are any residual effects from the work injury, those effects were not significant causative factors in Claimant's disability.

The Judge is persuaded that the cause of Claimant's permanent disability, if any, is not the June 25, 2002, injury. Claimant's complaints resulting from the June 25, 2002, accident resolved by May 2003. Any current inability to earn wages is not a result of the June 25, 2002, accident. The Judge is persuaded by the testimony and reports of Dr. Moe, Dr. Bernton, Dr. Quintero, and Mr. Macurak, and specifically rejects any contrary opinions or reports from Dr. Woodcock, Dr. Grenhart, and Dr. Zierk.

ORDER

1.Claimant sustained a compensable injury on June 25, 2002, with Employer in the form of a contusion and mild closed head injury. Claimant's right shoulder injury is not compensable. All other claim injuries are not

compensable and did not arise from the incident of June 25, 2002. The effects of the June 25, 2002, work injury have totally and completely resolved.

2.Claimant's claim for ongoing medical benefits is denied. Insurer is not liable for additional medical benefits.

3.Claimant's claim for permanent total disability benefits is denied.

4.This claim is closed.

DATED: *July 27, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-732-003

ISSUES

Whether Claimant is entitled to a general award of medical benefits to maintain her condition after reaching MMI. Claimant stated at hearing that no specific medical benefits were being requested at this hearing.

FINDINGS OF FACT

Based upon the evidenced presented at hearing, the ALJ finds as fact:

1. Claimant sustained an admitted injury to her low back on July 27, 2009 while employed as a firefighter for Employer. Claimant sustained injury from pulling on a charged fire hose.

2. Following the injury, Employer referred Claimant to Dr. Mark Paz, M.D. for treatment and Dr. Paz became an authorized treating physician. Dr. Paz referred Claimant to Dr. Nicholas Olsen, D.O. and to Dr. Franklin Shih, M.D. for further treatment and evaluation.

3. Dr. Olsen evaluated Claimant on June 18, 2008. Dr. Olsen's assessment was lumbar strain/sprain, status post non-diagnostic epidural steroid injection. Dr. Olsen felt that Claimant had not benefited enough from the epidural injections to justify repeating them.

4. Dr. Shih evaluated Claimant on October 6, 2008 and noted ongoing back symptomatology despite extensive multi-disciplinary intervention. Dr. Shih noted also that Claimant was using the medications Tylenol #3, Celebrex, and Cymbalta. Dr. Shih discussed the issue of MMI with Claimant and commented that maintenance care would consist of a trial of acupuncture, medication refills and medication monitoring through Dr. Paz.

5. Claimant was placed at MMI by Dr. Shih on October 20, 2008 and assigned 9% whole person impairment for the lumbar spine. Dr. Shih again recommended maintenance care consisting of the trial of acupuncture, medications and medical follow up with Dr. Paz.

6. Dr. Shih again evaluated Claimant on November 10, 2008 and noted no significant relief with the trial of accupunture. Dr. Shih noted that Claimant was using the medications Tylenol, Celebrex, and Plaquenil.

7. Dr. Paz evaluated Claimant for maintenance care on December 1, 2008 and again on February 24, 2009. Dr. Paz continued to prescribe medications Tylenol #3, Cymbalta and Celebrex.

8. In December 2002 Claimant began treatment with Dr. James Singleton, M.D., a rheumatologist, for complaints of joint pain and fatigue. Claimant continued to treat with Dr. Singleton through July 2006. Dr. Singleton diagnosed Claimant with arthalgias, myalgias, flares of arthritis and connective tissue disease. Dr. Singleton has prescribed Claimant the medications Vicodin, Vioxx, Feldene, Plaquenil, and Paxil for these diagnoses.

9. In August 2006 Claimant began treatment with another rheumatologist, Dr. Susan Boackle, M.D. Dr. Boackle assessed Claimant has having undifferentiated connective tissue disease. Dr. Boackle has prescribed Claimant the medications Plaquenil, Vicodin, Feldene, Paxil, Cymbalta and Hydrocodone-Aceteminophen.

10. Dr. Carolyn Burkhardt, M.D. performed a DIME on Claimant and issued a report dated March 17, 2009. In addition to reviewing records provided from Dr. Paz, Dr. Olsen and Dr. Shih concerning the treatment of Claimant's work injury of July 27, 2007 Dr. Burkhardt also reviewed the records from the Dr. Singleton and Dr. Boackle concerning treatment of Claimant's connective tissue disease as well as a number of other physicians who treated Claimant prior to the work injury. Dr. Burkhardt specifically noted a report from Dr. Shih dated May 5, 2008 in which Dr. Shih noted the possibility of multiple pain generators.

11. Dr. Burkhardt noted that at the time of her evaluation Claimant's medications were Cymbalta, Plaquenil, Feldene and Tylenol #3 and that Claimant's symptoms were about the same.

12. Following her review of the medical records submitted Dr. Burkhardt stated her impression that Claimant had not provided full disclosure for

the extent of her mixed connective tissue disease to the treating physicians for her work injury. Dr. Burkhardt opined that the work injury of July 27, 2007 was not responsible for all of Claimant's ongoing symptoms. Dr. Burkhardt agreed that Claimant had reached MMI and did not see any justification for further treatment including continuing maintenance. Dr. Burkhardt specifically stated that no further maintenance treatment was required for Claimant's lumbar strain related to the work injury of July 27, 2007.

13. Respondent filed a Final Admission of Liability on April 17, 2009 based upon Dr. Burkhardt's DIME report. This Final Admission denied liability for medical benefits after MMI.

14. Claimant continues to use Cymbalta, Plaquenil, Feldene and Vicodin that she received from her primary care physician. Claimant is now taking the Feldene prescribed by her rheumatologist instead of Celebrex. Claimant last saw Dr. Paz in February 2009, although she would be willing to return to him for maintenance treatment.

15. The ALJ finds the opinions and impressions of Dr. Burkhardt to be more persuasive than those of Dr. Paz or Dr. Shih regarding Claimant's need for medical treatment to maintain her condition after MMI. Based upon the opinion of Dr. Burkhardt, it is found that Claimant does not require any further maintenance medical treatment for the work related injury to her lumbar spine on July 27, 2007. Claimant has failed to prove an entitlement to post-MMI medical treatment by a preponderance of the evidence.

CONCLUSIONS OF LAW

16. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

17. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive.

Magnetic Engineering, Inc. v. Industrial Claim Appeals Office, 5 P.3d 385 (Colo. App. 2000).

18. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P. 2d 701 (Colo. App. 1999). The claimant must prove entitlement to *Grover* medical benefits by a preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature, subject to Respondents' right to contest compensability, reasonableness and necessity. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

19. The ALJ is persuaded by the opinions of Dr. Burkhardt as being based upon a more thorough review and understanding of Claimant's overall medical condition as it relates to the need for post-MMI medical care for Claimant's work injury. As stated by Dr. Burkhardt, the treating physicians for the work injury did not have an informed understanding of Claimant's non-work related conditions and treatment at the time they made recommendations for maintenance care. Dr. Paz and Dr. Shih did not recognize that the medications they were prescribing for Claimant in connection with the work injury were already being prescribed by Claimant's physicians treating her connective tissue disease. The ALJ concludes that Dr. Paz and Dr. Shih therefore could not have made informed decisions about whether treatment was necessary to maintain Claimant's condition after MMI related to the compensable injury as opposed to symptoms coming from the connective tissue disorder. The Claimant has failed to prove by a preponderance of the evidence that medical treatment after MMI is necessary to relieve Claimant from the effects of the work injury or to prevent future deterioration of Claimant's work related condition.

ORDER

It is therefore ordered that:

Claimant's claim for a general award of medical benefits after MMI is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: July 28, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-690-618

ISSUE

Whether Claimant has established by a preponderance of the evidence that SI joint injections are reasonable and necessary medical treatments designed to cure and relieve the effects of her industrial injury.

FINDINGS OF FACT

1. On April 13, 2006 Claimant suffered an admitted industrial injury to her back during the course and scope of her employment with Employer. She was diagnosed with a lumbosacral strain including muscle spasms.

2. Claimant initially received conservative treatment and was placed at Maximum Medical Improvement (MMI) in 2007. However, Claimant continued to experience back symptoms and the MMI determination was retracted. Based on the recommendation of Authorized Treating Physician (ATP) Jeffrey B. Kleiner, M.D. Claimant underwent L4-L5 disc replacement surgery.

3. Despite her surgery, Claimant continued to experience lower back, right buttocks and lower extremity pain. Because of Claimant's continued symptoms, Dr. Kleiner referred her to Bradley D. Vilims, M.D. for a right L4-L5 and L5-S1 transforaminal epidural steroid injection. On September 26, 2008 Dr. Vilims performed the procedure for diagnostic and therapeutic purposes.

4. Claimant received a "significant palliative benefit" from the epidural steroid injection, but continued to experience left-sided buttocks pain. Dr. Kleiner thus referred Claimant to Dr. Vilims for a left sacroiliac (SI) joint injection to determine whether any of her pain was related to the left SI joint. Dr. Vilims performed the injection on November 14, 2008.

5. On November 14, 2008 Claimant also underwent a CT scan of her SI joints. The scan revealed normal results.

6. On January 9, 2009 Claimant returned to Dr. Vilims for bilateral SI joint injections because she suffered "persistent axial low back pain and buttocks pain." Dr. Vilims noted that the purpose of the injections was to either confirm or refute Claimant's diagnosis of SI joint dysfunction and to obtain therapeutic benefit. After performing the procedure, Dr. Vilims concluded that Claimant's "[p]

ersistent axial low back and buttocks pain" was "not related to the bilateral sacroiliac joint."

7. On January 21, 2009 Claimant again visited Dr. Vilims. He stated that Claimant's symptoms had been improving as long as she did not engage in aggressive physical therapy. He commented that Claimant suffered from persistent buttocks pain that was greater on the right than on the left. Dr. Vilims opined that Claimant's pain was most likely caused by a nerve irritation "although a sacroiliac joint component is not being completely excluded."

8. On February 11, 2009 Claimant again returned to Dr. Vilims for treatment. He remarked that Claimant had suffered a flare-up of her symptoms and that her providers needed to be more definitive in ascertaining the etiology of her pain. He sought to schedule her for bilateral SI joint injections to "either confirm or refute an SI joint etiology." Based on Dr. Vilims' request and the recommendation of Dr. Kleiner, Claimant seeks authorization for additional SI joint injections.

9. On February 23, 2009 Henry J. Roth, M.D. prepared a Comprehensive Record Review Report. The Report addressed Dr. Vilims' request for another set of bilateral SI joint injections. Dr. Roth reviewed Claimant's medical records and concluded that the SI joints are not the source of Claimant's pain. He remarked that Claimant has had "diffuse bilateral lumbosacral discomfort with evidence of discomfort in the region of the SI joints since before her claim." Dr. Roth noted that Claimant's symptom pattern had existed since her coccyx fracture in 2005. He explained that, because Claimant had received extensive conservative and invasive therapies without any long-lasting benefit, it is not reasonable to expect that additional bilateral SI joint injections will provide any relief. Dr. Roth also remarked that bilateral SI joint injections would not prove beneficial because Claimant's CT scans revealed normal SI joints. He thus determined that additional bilateral SI joint injections are neither reasonable nor necessary medical treatments designed to cure and relieve the effects of Claimant's April 13, 2006 industrial injury.

10. Claimant testified at the hearing in this matter that she had received a number of injections similar or identical to the injections requested by doctors Kleiner and Vilims. She estimated that she had received approximately nine or ten injections during the course of her medical treatment. Claimant commented that the injections provided varying degrees of effectiveness from temporary to significant. She also remarked that, although she suffered a previous injury involving a fractured coccyx, she had not received treatment for the injury since November 2005.

11. Claimant has failed to demonstrate that it is more probably true than not that SI joint injections constitute reasonable and necessary medical treatment designed to cure and relieve the effects of her industrial injury. The record reveals that Claimant has had several SI joint injections that have

provided varying degrees of effectiveness. When Claimant visited Dr. Vilims on January 9, 2008 he noted that the purpose of the SI joint injections was to confirm or refute the diagnosis of an SI joint dysfunction. After performing the injections he commented that Claimant's persistent axial low back and buttocks pain was not related to the bilateral SI joint. On January 21, 2009 Dr. Vilims again remarked that Claimant's persistent buttocks pain was most likely caused by a nerve irritation. Claimant's CT scan also confirmed that her SI joint was normal. Furthermore, after conducting an extensive records review Dr. Roth explained that Claimant had not received any long-lasting benefit after multiple therapies and had a normal SI joint CT scan. He thus opined that additional bilateral SI joint injections would not provide any benefit. Dr. Roth therefore persuasively determined that additional bilateral SI joint injections were neither reasonable nor necessary medical treatments designed to cure and relieve the effects of Claimant's April 13, 2006 industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716

(Colo. 1994). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. *In re of Parker*, W.C. No. 4-517-537 (ICAP, May 31, 2006); *In re Frazier,* W.C. No. 3-920-202 (ICAP, Nov. 13, 2000). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met her burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

5. As found, Claimant has failed to demonstrate by a preponderance of the evidence that SI joint injections constitute reasonable and necessary medical treatment designed to cure and relieve the effects of her industrial injury. The record reveals that Claimant has had several SI joint injections that have provided varying degrees of effectiveness. When Claimant visited Dr. Vilims on January 9, 2008 he noted that the purpose of the SI joint injections was to confirm or refute the diagnosis of an SI joint dysfunction. After performing the injections he commented that Claimant's persistent axial low back and buttocks pain was not related to the bilateral SI joint. On January 21, 2009 Dr. Vilims again remarked that Claimant's persistent buttocks pain was most likely caused by a nerve irritation. Claimant's CT scan also confirmed that her SI joint was normal. Furthermore, after conducting an extensive records review Dr. Roth explained that Claimant had not received any long-lasting benefit after multiple therapies and had a normal SI joint CT scan. He thus opined that additional bilateral SI joint injections would not provide any benefit. Dr. Roth therefore persuasively determined that additional bilateral SI joint injections were neither reasonable nor necessary medical treatments designed to cure and relieve the effects of Claimant's April 13, 2006 industrial injury.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request for additional SI joint injections is denied and dismissed.

2. Any remaining issues that have not been resolved by this Order are reserved for future determination.

DATED: July 28, 2009.

Peter J. Cannici
Administrative Law Judge

ISSUES

The issue before the ALJ was compensability.

The ALJ concludes below that the Claimant's claim is not compensable and therefore does not address any additional issues.

FINDINGS OF FACT

23. Claimant was hired in May 2000 as a cashier for the Respondent-Employer. She was transferred to the service desk sometime in 2007. As a cashier Claimant was assigned to the cash register where she would scan items for purchase and bag the purchases. In each of these positions Claimant worked from 25 to 35 hours per week.

24. On the service desk Claimant's duties also involved scanning but included making entries into the computer for special orders for contractors, as well as typing notes. Claimant would also answer phones, take care of returned items, and unload freight as required.

25. On January 10, 2009 Claimant was in the special order cage unloading cabinets. Claimant was attempting to unload the cabinet on top of the load when she felt a pop in her wrist. Claimant waited a while then sought help to continue unloading the cabinets. Claimant experienced numbness, tingling, and pain.

26. Claimant has had previous issues since 2004 with numbness and tingling but has always felt it was manageable. She has worn braces on her wrists at night that were given to her by her mother.

27. Claimant did not file any workers' compensation claim in 2004 because she was always able to work without limitations.

28. In mid-20087 Claimant's wrist condition started getting worse with more consistent pain and numbness and it began hurting at work. To compensate Claimant would enlist the aide of others to help her when necessary.

29. Claimant reported the January 10, 2009 incident to an assistant manager, telling the assistant manager that she thought she had carpal tunnel syndrome. Claimant was sent to the Respondent-Employer's workers' compensation doctor.

30. On April 28, 2009 Dr. Eric Ridings performed an independent medical evaluation at the request of the Respondent-Insurer. Dr. Ridings was qualified at hearing as an expert in Physical Medicine and Rehabilitation. Dr. Ridings was also Level II certified by the Division of Workers' Compensation (DOWC).

31. Based upon Dr. Ridings examination, review of medical records, and interview and history taken from the Claimant, he opined that Claimant's CTS was not a work-related condition.

32. Dr. Ridings found that Claimant's symptoms began approximately a year prior to his examination and the symptoms only began to occur in the evening. Dr. Ridings observed that the Claimant's job was not one where it was highly repetitive work and there was no strong gripping involved. Dr. Ridings relied upon the guidelines produced by the DOWC, specifically Rule 17, in arriving at his opinion.

33. Dr. Timothy Hall also examined Claimant and provided an opinion that Claimant's condition was a work-related condition.

34. Dr. Ridings opined that Dr. Hall was relying on incomplete information.

35. The ALJ finds that Dr. Ridings' opinions are the more credible medical evidence and adopts those opinions as findings of fact.

36. Claimant has failed to establish by a preponderance of the evidence that she sustained a work-related injury or occupational disease of her upper extremities that arose out of and in the course of her employment with the Respondent-Employer.

CONCLUSIONS OF LAW

1. C.R.S. §8-43-201 provides, "(a) Claimant in a workers' compensation claim shall have the burden of proving entitlement to benefits by a preponderance of the evidence; the facts in a workers' compensation case shall not be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer, and a workers' compensation case shall be decided on its merits." *Also see Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590, 592 (Colo. App. 1998) ("The Claimant has the burden of proving an entitlement to benefits by a preponderance of the evidence*."); Lerner v. Wal-Mart Stores, Inc.*, 865 P.2d 915, 918 (Colo. App. 1993) ("The burden is on the Claimant to prove his entitlement to benefits by a preponderance of the evidence.").

2. Proof by a preponderance of the evidence requires Claimant to establish that the existence of a contested fact is more probable than its nonexistence. *See Hoster v. Weld County Bi-Products, Inc.*, W.C. No. 4-483-341 (ICAO March 20, 2002). In deciding whether the Claimant has met their burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and

actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. As stated above, the ALJ concludes that the more credible medical and other evidence establishes that Claimant's upper extremity condition did not arise out of and in the course of her employment with the Respondent-Employer.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: July 28, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-763-929

ISSUES

- Did the claimant prove by a preponderance of the evidence that the disease of bilateral carpal tunnel syndrome was proximately caused, aggravated or accelerated by the hazards of her employment so as to constitute a compensable occupational disease?

- Did the claimant prove by a preponderance of the evidence that she is entitled to reasonable and necessary medical benefits, including surgery, for treatment of the alleged occupational disease?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

On the date of hearing the employer has employed the claimant for approximately 10 years. The employer is engaged in health care services. The claimant works principally as a sales representative soliciting business for the employer.

The claimant's job requires her to use the telephone and to operate a computer keyboard and a ten-key machine while speaking with customers. The claimant performs these tasks for approximately 90 percent of the workday. The claimant testified that the employer has two seasons. During the "off season" she works approximately 55 hours per week. During the busy season she works 60 to 70 hours per week.

The claimant testified that in November or December 2007 she began to experience symptoms of what has been diagnosed as carpal tunnel syndrome (CTS). The claimant's symptoms include pain in both wrists, numbness of the hand, thumb and first three fingers, and pain running into her forearm. The claimant visited her primary care physician (PCP) for treatment of her symptoms in May 2008. On May 27, 2008, the claimant advised a nurse practitioner that she had a history of CTS 12 years ago.

The claimant admitted that she had aching in her hands for approximately five years before she began working for the employer, and recalled that these symptoms were diagnosed as tendonitis. However, the claimant stated that the CTS symptoms are different. In particular, the claimant stated that, unlike the CTS symptoms, the "tendonitis" symptoms did not cause her to wake up at night, and did not cause numbness in her hands.

The claimant testified that when she is not working the CTS symptoms tend to subside. Conversely the symptoms tend to increase when she returns to work. The claimant was off work for approximately 6 weeks in January and February 2008 for treatment of a non-work related condition. The claimant recalled that her CTS symptoms subsided when she was off work, but increased when she returned to work.

At some point in 2008 the claimant sought treatment of her symptoms from her primary care physician. This physician suspected the claimant's symptoms represented CTS and were related to her employment. The claimant reported a work-related injury and the employer referred the claimant to Dr. Paul Fournier, M.D. at its "on the job" clinic. Dr. Fournier is board certified in occupational medicine and is level II accredited.

Dr. Fournier first examined the claimant on June 5, 2008. Dr. Fournier noted that the claimant gave a history of developing symptoms of numbness, tingling and intermittent pain in the right hand six months ago. The claimant also reported intensification of her right-sided symptoms four weeks prior to the examination, plus the development of symptoms in the left hand. The claimant also advised Dr. Fournier she experienced "tendonitis-type hand problems dating back many

years ago." Dr. Fournier assessed symptoms consistent with bilateral median nerve compression neuritis. He referred the claimant for elctrodiagnostic testing, recommended an ergonomic evaluation of the claimant's workstation, and prescribed Naprosyn. Dr. Fournier stated that his determination of whether the claimant's symptoms were related to her employment would have to await additional diagnostic information.

Dr. Jim Rafferty, D.O., also examined the claimant on June 5, 2008. Dr. Rafferty completed a physician's report of workers' compensation injury and stated that his "objective findings" were consistent with work-related CTS. Dr. Rafferty stated the claimant was under temporary work restrictions and would be referred for a surgical consult.

On June 10, 2008, the claimant underwent electrodiagnostic testing of both upper extremities. These tests were positive for moderate CTS affecting both the left and right median nerves.

On June 20, 2008, Dr. Fraser Leversedge, M.D., examined the claimant for the purpose of conducting a surgical evaluation. Dr. Leversedge's notes reflect the claimant gave a history "progressive bilateral hand pain, numbness and tingling presents intermittently (for many years) but most notably becoming symptomatic over the past one to two months." The claimant reported that she used a keyboard extensively and attributed her symptoms to this activity. Dr. Leversedge assessed bilateral CTS and recommended the claimant undergo "staged carpal tunnel release." Dr. Leversedge further stated that because the claimant gave a history of intermittent symptoms for many years, and in the absence of a specific inciting event, it was his "impression that the patient's condition is consistent with that of idiopathic" CTS. Finally, Dr. Leversedge stated that, "current medical literature is without supporting evidence for keyboard use as a causative factor for carpal tunnel syndrome."

On June 23, 2008, Kristine Couch, OTR, performed an ergonomic evaluation of the claimant's workstation. Ms. Couch recommended the claimant be provided an ergonomic keyboard, that the height of her chair be changed, and that the claimant use a different computer mouse. Ms. Couch also recommended that the claimant take breaks from keyboarding and perform stretches.

On June 27, 2008, the claimant returned to Dr. Fournier. Dr. Fournier noted the claimant's workstation had undergone an ergonomic evaluation and that "no significant problems were found." Dr. Fournier advised the claimant that in his opinion her bilateral CTS is not work related. Dr. Fournier stated that current medical literature does not support a causal link between "normal keyboarding" and CTS, and that the claimant exhibited persistent symptoms despite being away from work. Dr. Fournier also agreed with Dr. Leversedge and Dr. Rafferty (who saw the claimant on June 16, 2008) that the claimant's CTS was not caused by work. Dr. Fournier also recommended restrictions of "stretch breaks "

for 1 to 2 minutes every 30 minutes. He also referred the claimant back to her PCP for follow-up of the bilateral CTS.

The claimant returned to her personal physician. In a note dated August 11, 2008, a physician's assistant who saw the claimant opined the CTS was likely "aggravated" by her work, but that "cause is difficult to ascertain." "Kerry G. Perloff," presumably the physician's assistant's supervising physician, cosigned this note.

On October 1, 2008, Dr. David J. Conyers, M.D., performed an independent medical examination (IME) at the claimant's request. Dr. Conyers performed a physical examination and reviewed the claimant's medical records. Dr. Conyers opined the claimant suffers from bilateral CTS and agreed with Dr. Leversedge that she is a good candidate for carpal tunnel decompression. Dr. Conyers opined that the etiology of the claimant's CTS was "unclear." Dr. Conyers explained to the claimant that "evidence-based research has indicated that keyboard work does not cause carpal tunnel syndrome though it can cause irritation of carpal tunnel syndrome." Dr. Conyers stated the claimant was "not accepting of this."

On October 16, 2008, Dr. Conyers wrote a letter to claimant's counsel after they had a conversation on that date. Dr. Conyers stated that he and counsel agreed the claimant had preexisting CTS. He further noted the claimant did extensive keyboard work and that her symptoms "decreased while she was off work for a 6-week period." Dr. Conyers stated that despite the recent ergonomic changes to the claimant's workstation she continued to "aggravate her carpal tunnels doing this job" to "the point she is in need of carpal tunnel decompression bilaterally to control her symptoms." Dr. Conyers opined that the "keyboard, mousing and hand writing is the straw that broke the camel's back."

Dr. Fournier gave a deposition on February 24, 2009. Dr. Fournier stated that current medical literature does not support a causal link between the activity of keyboarding and the development of CTS absent "very abnormal posturing." Dr. Fournier stated that both the Colorado Medical Treatment Guidelines and the American College of Occupational and Environmental Medicine guidelines support this analysis. Dr. Fournier explained that CTS is associated with work that requires an employee to engage in forceful hyperflexing or hyperextension of the wrist, such as the knife work done by meat cutters.

Dr. Fournier also testified that when he first saw the claimant on June 5, 2008, he restricted her to doing no more than 50 percent of her usual keyboarding, and directed her to stretch every 30 to 60 minutes. Dr. Fournier stated that he did not impose these restrictions because he thought the claimant's work activities caused or aggravated the underlying CTS, but instead imposed them for the purpose of helping the claimant to manage her symptoms. Dr. Fournier further stated that he recommended the ergonomic study of the claimant's workstation and opined the claimant should follow the recommendations in order to manage

her symptoms. Dr. Fournier also testified that a mere increase in symptoms of CTS does not equate to an increase in the underlying physical pathology of the disease. Dr. Fournier explained that studies based on biopsies and electrodiagnostic testing of patients who perform keyboarding and experience increased symptoms do not demonstrate worsening of the underlying disease. Dr. Fournier stated that symptoms are "subjective," and patients "can have a flare in symptoms" without the nerve "getting worse."

Dr. Fournier testified that he relied on several texts when forming his opinions, including *A Physician's Guide to Return to Work.* An excerpt from this treatise that discusses CTS is contained in the record. Concerning work-related causes of CTS, the treatise states that NIOSH "review of studies suggested that only in combination of all the ergonomic factors is there strong evidence of causation." The "ergonomic factors" mentioned are repetition, force, posture, and vibration. The treatise also states:

> Although popular media suggests that keyboards cause CTS, the science shows otherwise. Nine studies have reviewed this relationship. The results show that keyboards are safe to use and do not cause CTS. Furthermore, keyboard design had no effect on incidence of CTS. Symptoms may increase with many activities, including the use of keyboards, but keyboards do not cause CTS.

A Physician's Guide to Return to Work also discusses "tolerance" for CTS symptoms of pain and paresthesias. The treatise states:

> Tolerance for symptoms like pain and paresthesias is the most frequent problem. If tests of nerve function confirm that CTS is the correct diagnosis, many physicians would feel the symptoms are believable and the condition is at a level of severity that justifies work restrictions. This is not work restriction based on risk, but rather restriction based on tolerance in the presence of severe, objectively documented pathology.

The claimant failed to prove it is more probably true than not that the alleged hazards of her employment, particularly keyboarding, caused, aggravated or accelerated the disease of CTS so as to result in a compensable occupational disease and the consequent need for surgery. The ALJ finds Dr. Fournier credibly opined that the claimant's keyboard activity did not cause or aggravate her CTS. Dr. Fournier persuasively explained that the medical literature does not support the conclusion that keyboarding causes CTS, or aggravates preexisting CTS, in the sense that it causes underlying nerve damage. Rather, Dr. Fournier persuasively opined that keyboarding, absent other complicating factors including unusual force and posture, may elicit *symptoms* of underlying CTS without actually causing or aggravating the disease process. Dr. Leversedge persuasively corroborates Dr. Fournier's analysis in his report of June 20, 2008. Moreover, the ALJ finds that the discussion of CTS contained in the treatise *A*

Physician's Guide to Return to Work corroborates and supports Dr. Fournier's opinion concerning causation. The treatise indicates that medical research and studies do not support the inference that CTS is caused by keyboarding alone. Rather, keyboarding would only be considered a causative factor in the presence of other factors such as force and posture. As shown by his testimony and report of June 27, 2008, Dr. Fournier was well aware of the circumstances of the claimant's employment and the results of the ergonomic study, but nevertheless determined that the hazards of the claimant's employment were not sufficient to be considered the cause of or aggravating factors in the claimant's CTS.

The ALJ finds that the opinions of Dr. Conyers do not constitute persuasive evidence in support of the claimant's theory that the duties of her employment caused CTS or aggravated preexisting CTS. In his initial report of October 1, 2008, Dr. Conyers opined the etiology of the claimant's CTS was "unclear" and advised the claimant of the medical studies indicating that keyboarding CTS does not cause CTS. It was only after a conversation with claimant's counsel, the contents of which are not established by the record, that Dr. Conyers became more certain that the claimant's employment was a factor that aggravated "preexisting" CTS so as to necessitate medical treatment including surgery.

The ALJ is not persuaded by the opinions of the physician's assistant and Dr. Perloff. Although their report of August 11, 2008, states the CTS was likely "aggravated" by the claimant's duties of employment, it is unclear from the note whether the term "aggravation" is meant to indicate that the duties of employment were actually damaging the claimant's median nerve, or meant to state that the duties of employment were eliciting symptoms of a non-work related CTS. This is particularly true since the note also indicates that the "cause" of the CTS "is difficult to ascertain."

The ALJ finds the claimant credibly testified that her CTS symptoms subsided when she was off work in January and February 2008. However, the ALJ finds that this fact is not of sufficient weight to support the inference that the duties of employment caused or aggravated the underlying CTS. The ALJ is persuaded from the histories the claimant gave to the nurse practitioner in May 2008, to Dr. Fournier and to Dr. Leversedge that she had symptoms of CTS, albeit not as severe as she currently has, since before she commenced her job with the employer. In light of this fact the ALJ credits the opinion of Dr. Fournier that the keyboarding had the effect of eliciting symptoms of the underlying CTS without being a causative factor in the development or progression of the disease. The ALJ finds that the CTS symptoms the claimant experiences when she works are the natural recurrent result of the underlying non-industrial disease process , and that the disease of CTS was not caused and is not aggravated by the duties of the claimant's employment.

Evidence and inferences inconsistent with these findings of fact are not credible or persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

CAUSE OF ALLEGED OCCUPATIONAL DISEASE OF CTS

The claimant argues that the evidence establishes that the hazards of her employment, in the form of excessive and repetitive keyboard activity, caused CTS or aggravated preexisting CTS so as to result in a compensable occupational disease. The claimant further argues that the occupational disease proximately caused the need for surgery to treat the bilateral CTS. The ALJ disagrees.

The claimant was required to prove by a preponderance of the evidence that at the time of the injury she was performing service arising out of and in the course of the employment, and that the injury or occupational disease was proximately caused by the performance of such service. Section 8-41-301(1)(b) & (c), C.R.S.; *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo. App. 1991). The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time,

place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). An "occupational disease" is defined by §8-40-201(14), C.R.S. as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P. 2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once the claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

The mere occurrence of symptoms at work does not require the ALJ to find that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any preexisting condition or disease process. Rather, the occurrence of symptoms at work may represent the logical and recurring consequence of, or the natural progression of, a preexisting condition or disease process that is unrelated to the employment. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000); *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office, supra*; *Schulte v. Morgan County,* W.C. No. 4-707-046 (ICAO August 15, 2008).

The ALJ concludes the claimant failed to prove that the disease of CTS was proximately caused or aggravated by the duties of her employment. As specifically detailed in Findings of Fact 20 through 23, the ALJ credits the opinions of Dr. Fournier, as corroborated by Dr. Leversedge, that the medical literature does not support the conclusion that there is a causal connection between keyboarding and the development or progression of CTS, absent other accompanying hazards such as posture and force. The ALJ also credits the

opinion of Dr. Fournier, as expressed in his testimony and written note of June 27, 2008, that those additional hazards were not sufficiently present in the claimant's work environment to warrant an inference of causation. The ALJ further concludes the opinions of Dr. Fournier and Dr. Leversedge are supported by the cited portions of *A Physician's Guide to Return to Work*.

The ALJ is not persuaded by the contrary opinions of Dr. Conyers and Dr. Perloff. As determined in Finding of Fact 21, the opinions expressed by Dr. Conyers appear somewhat contradictory, and may have been influenced by an off the record conversation between Dr. Conyers and the claimant's attorney. In such circumstances the opinion of Dr. Conyers is not credible or persuasive. As determined in Finding of Fact 22 Dr. Perloff's opinion concerning causation is unclear at best and is not entitled to significant weight.

Finally, although the ALJ believes the claimant's CTS symptoms subsided when she was off of work, that fact does not persuade the ALJ that the duties of her employment caused or aggravated the CTS. As determined in Finding of Fact 23, the ALJ is persuaded the claimant exhibited CTS symptoms before she began work for the employer. The ALJ is also persuaded by the testimony of Dr. Fournier that the duties of the claimant's employment would tend to elicit CTS symptoms without actually aggravating the underlying disease process.

In these circumstances the ALJ concludes the claimant has failed to meet her burden of proof to establish the requisite causal relationship between CTS and the duties of her employment. Because the claimant has failed to prove the existence of a compensable occupational disease, the ALJ need not reach the question of whether the claimant is entitled to medical benefits in the form of surgery to repair her carpal tunnels.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claim for workers' compensation benefits in W.C. No. 4-763-929 is denied and dismissed.

DATED: July 28, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-786-809

ISSUES

Has the Claimant established by a preponderance of the evidence that she suffered an injury arising out of and in the course of her employment with the Respondent-Employer.

The ALJ concludes below that Claimant's injuries are not compensable and therefore does not address any other issues herein.

FINDINGS OF FACT

1.Claimant was hired as a security guard for Respondent-Employer on or about November 5, 2007.

2.Claimant was injured on February 22, 2009 when she fell on some stairs while conducting her rounds.

3.Claimant filled out the employer's "Workers' Compensation Claim Reporting Form" on February 24, 2009. In it she described the accident and indicated, "Was walking up the stairs and my ankle gave out. Fell and hurt left side of body." Claimant also indicates that there were two witnesses, Mr. Harry Fries and Mr. Wayne Sterling.

4.Claimant told Mr. Fries mere minutes after the incident in question that she had been walking up the stairs when her ankle gave out and she fell on the stairs.

5.Mr. Sterling recalls that claimant stated that she was going up the stairs and her ankle went out causing her to fall on the steps hitting her left knee and left ribs.

6.Claimant has reported to her authorized treating physician, Dr. Daniel M. Peterson, that she fell "walking up a flight of stairs when my right ankle gave out on me…" Dr. Peterson noted that claimant's "right ankle just gave way and twisted for no apparent reason…"

7.The stairs where claimant was injured are not extraordinary in any way. They contain anti-slip vinyl and a handrail just as any other common stairs would.

8.The claimant did not fall down the stairs from a height or from one of the first steps. Rather, claimant was walking up the stairs and fell forward onto her side. Mr. Sterling recalls that the paramedics assisted claimant down approximately five to seven steps on one foot following the incident.

9.Claimant testified at hearing. Claimant asserts she was walking up the stairs when her right ankle locked up and gave out on her, causing her to fall on the stairs.

CONCLUSIONS OF LAW

1. An injury resulting from the concurrence of a preexisting condition and a hazard of employment is compensable. *H & H Warehouse v. Vicory*, 805 p.2d 1167 (Colo.App. 1990). Even where the direct cause of an accident is the employee's preexisting idiopathic disease or condition, the resulting disability is compensable where the conditions or circumstances of employment have contributed to the injuries sustained by the employee. *Ramsdell v. Horn*, 781 P.2d 150 (Colo.App. 1989). Thus, even if the direct cause of an employee's fall is a preexisting idiopathic condition, any resulting injury caused by a special employment hazard is compensable, so long as the employment condition is not ubiquitous and generally encountered. *Gates Rubber Co. v. Industrial Commission*, 705 P.2d 6 (Colo.App. 1985); *Ramsdell v. Horn*, *supra*. In *Gates Rubber Co. v. Industrial Commission*, the court held that a level concrete floor is not a special hazard because it is a condition found in many non-employment locations.
2. The ALJ concludes that the claimant fell while making her rounds as a result of an idiopathic condition. Claimant did not have a pre-existing ankle condition and thus the special hazard rules do not apply.
3. Claimant's injuries were not precipitated by her conditions of employment. Rather, claimant's ankle inexplicitly gave way. It was Claimant's ankle locking up and giving way that precipitated the subsequent injuries. There is insufficient evidence in the record to establish that any condition of employment was responsible for Claimant's ankle locking up and giving way. Thus, Claimant's injuries did not arise out of her employment with the Respondent-Employer.
4. It is clear that her ankle locking up and giving way caused claimant's injuries; however, there has been insufficient credible evidence for the ALJ to infer that a condition of employment caused the ankle issues. The reason or reasons for the ankle locking up and giving way are truly unexplained.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: July 28, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-729

ISSUES

The issues before the ALJ are Claimant's attempt to overcome the Division Independent Medical Examiner's opinion with respect to Maximum Medical Improvement, permanent partial impairment, and medical benefits for psychiatric care.

FINDINGS OF FACT

1. The Claimant was employed by Memorial Health System as an occupational therapist. On February 15, 2007, she sustained an admitted injury to her low back while transferring a patient.

2. The Claimant received treatment, consisting of physical therapy, sacroiliac joint injections, chiropractic care and an orthopedic surgical consultation without any benefit.

3. The Claimant had an MRI performed on March 21, 2007, which was normal.

4. The Claimant also sought psychological treatment with Trudy Dawson from August 21, 2007 through February 2009. Ms. Dawson discharged the Claimant as of February 11, 2008, indicating that the Claimant was placed at MMI and could continue supportive care through her health insurance.

5. Dr. Castrejon, her authorized treating physician, placed the Claimant at maximum medical improvement on December 19, 2007. He opined the Claimant had sustained a 22% whole person impairment.

6. The Claimant underwent a Division IME with Dr. Jenks on April 3, 2008. Dr. Jenks determined the Claimant not to be at MMI and recommended treatment directed to the right L5-S1 facet joint, to possibly include an L5 facet injection or medial branch blocks and a facet rhizotomy.

7. During his examination, Dr. Jenks also noted that the Claimant was quite tearful and recommended that she continue treatment for her depression.

8. Claimant returned to Dr. Castrejon following the Division IME for implementation of treatment as recommended by Dr. Jenks. Dr. Castrejon referred the Claimant to Dr. Ford. She received right L5-S1 facet injections on June 12 and July 10, 2008. She also received an L4-5 medial branch block on July 10, 2008 and a rhizotomy at L4-5 on August 4, 2008.

9. Dr. Castrejon also referred the Claimant back to Trudy Dawson and Ms. Dawson began to treat the Claimant for depression.

10. On October 7, 2008, Claimant's condition had not changed with the prescribed treatment and Dr. Castrejon determined nothing further could be offered. He noted in his report dated October 27, 2008, that her findings were essentially identical to those documented at the time of her release and initial MMI. She had no new or advancing neurological changes. Dr. Castrejon referred the Claimant back to Dr. Jenks for a follow-up Division IME.

11. The follow-up Division IME occurred on November 10, 2008. Dr. Jenks determined the Claimant to be at MMI as of November 10, 2008. By the time she reached MMI on November 10, 2008, the Claimant had undergone chiropractic treatment, physical therapy, psychological counseling, biofeedback, medial branch blocks, facet blocks, SI joint injections and a rhizotomy. Dr. Jenks gave the Claimant a 13% spinal impairment, broken down as follows: 5% for Table 53; 8% for loss of range of motion; 13% whole person, and; a 2% psychiatric impairment.

12. Dr. Jenks testified that, because the Claimant had undergone a rhizotomy, he would correct his rating to include a 7% impairment under Table 53 for a rhizotomy. He further testified that he had referred the Claimant to a therapist whom she had seen previously at Memorial Hospital for range-of-motion testing. He also testified that, with some individuals like Ms. Johnson, who he believed would probably have some invalidity based on what he knew about her, he would refer her to a physical therapist. He believed the therapist was trained in performing range-of-motion measurements and would have the time to obtain accurate measurements. He also testified that the AMA Guidelines did not dictate that he had to perform his own range-of-motion measurements and he specifically did not adopt anyone else's range-of-motion measurements, but did obtain his own range-of-motion measurements for his Division IME through a physical therapist.

13. The first range-of-motion measurement testing was performed on November 24, 2008. The testing performed on all ranges of motion was internally consistent between the three sets of tests performed. However, the flexion range-of-motion measurement was deemed invalid (the tightest

straight leg raise was 10° greater than the sum of the sacral flexion and extension). Accordingly, Dr. Jenks referred the Claimant for a second set of range-of-motion measurements, which was performed by the same therapist, on December 8, 2008. The range-of-motion testing for all planes of range of motion was internally consistent between the three sets of range-of-motion measurements performed. Again, the range-of-motion measurements for flexion were invalid. Dr. Jenks stated he had correctly disregarded the flexion range-of-motion measurements but had incorrectly disregarded the extension range-of-motion measurements. He corrected the mistake during his deposition, testifying that he would provide her with a 6% whole person impairment for extension. He therefore corrected his whole person impairment rating to a 20% spinal impairment plus a 2% psychological impairment, totaling a 22% whole person impairment.

14. Dr. Jenks testified that the 2% psychological impairment, in his opinion, was valid and consistent because the Claimant was not tearful during the final impairment rating in November 2008. Dr. Jenks further indicated that the Claimant had had adequate psychological treatment by Ms. Dawson from August 2007 through February 2009. Dr. Jenks believed the Claimant's condition was stable and further counseling was not reasonable or necessary treatment. He further testified that the Claimant's subjective complaints had no physiologic or anatomic basis and, therefore, he could have provided the Claimant with a 0% impairment. He further indicated that he could find no pain generator for Claimant's low back pain.

15. Dr. Hall saw the Claimant on February 20, 2009, at the request of Claimant's counsel. He was asked to perform two sets of range-of-motion measurements. Dr. Hall did not generate a report at the request of Claimant's counsel because the Claimant's range-of-motion measurements were invalid. He destroyed the testing from his file.

16. Video surveillance was conducted on March 30, 2009. The video showed the Claimant bending, with sustained bending at the waist for several minutes at a time.

17. Based on the video surveillance, Dr. Jenks felt it further supported his opinion that it was appropriate to disregard her flexion range of motion.

18. Claimant had additional range-of-motion testing performed at Optima on April 6, 2009. The Claimant's range-of-motion testing was valid.

19. The Claimant was then referred, at the request of opposing counsel, to Dr. Rook on April 8, 2009. Dr. Rook testified that the Claimant was not at MMI and needed a discogram.

20. Dr. Rook determined the Claimant also had a spinal impairment rating of 7% and a 22% loss of range of motion rating, as well as a 13% psychiatric impairment.

21. Neither Dr. Jenks nor Dr. Castrejon could explain why there was such a disparity in flexion when all the other planes of ranges of motion were similar amongst all three physicians. Dr. Castrejon further testified at hearing that Claimant's symptoms were not based on objective findings. He also referred Claimant to a physical therapist for range-of-motion measurements because he wanted more objective range-of-motion testing.

22. Dr. Castrejon and Dr. Jenks both testified that, based on the surveillance video, the Claimant was bending greater than 25°, beyond that noted in Dr. Rook's range-of-motion measurements performed by Optima.

23. Dr. Jenks and Dr. Castrejon both testified that the Claimant did not need a discogram or an MRI. Dr. Jenks specifically stated that discograms are invasive and should not be performed if there is no indication for them.

24. Dr. Castrejon and Dr. Jenks have testified that no further psychological treatment is reasonable and necessary. In addition, Dr. Castrejon testified that further counseling would be beyond the Workers' Compensation Medical Treatment Guidelines.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P. 3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004).

5. "Clear and convincing evidence" is defined as evidence that is stronger than a preponderance, is unmistakable and is free from serious or substantial doubt. *DiLeo v. Koltnow*, 613 P.2d 318 (Colo. 1980). In other words, in order to overcome the DIME report, there must be evidence that proves that it is highly probable that the Division IME physician's opinions are incorrect. *Metro Moving and Storage Company v. Gussert*, 914 P.2d 411 (Colo. App. 1995). All reports and testimony of the Division IME are to be considered in determining what is the determination of the Division IME and are also subject to the clear and convincing evidence standard. *Lambert & Sons, Inc. v. Industrial Claim Appeals* Office, 984 P.2d 656 (Colo. App. 1998). Proof of deviation from the rating protocols of the AMA Guides does not require the conclusion that the rating itself is incorrect or has been overcome by clear and convincing evidence. Rather, proof of a deviation is evidence which the ALJ may weigh in deciding whether the parties seeking to overcome the DIME physician's rating has carried its burden of proof. *Wilson v. Industrial Claim Appeals Office*, supra. *Rivale v. Beta Metals, Inc.*, W.C. No. 4-265-360 (April 18, 1999), affirmed; *Rivale v. Industrial Claim Appeals Office*, (Colo. App. 98CA0858, January 28, 1999) (stipulation that DIME physicians who violate the AMA Guides by failing to repeat invalid range-of-motion measurements did not require a conclusion that the DIME rating was invalid or overcome as a matter of law).

6. Claimant has failed to overcome Dr. Jenks' opinion by clear and convincing evidence when taken in totality of all the circumstances. Dr. Jenks performed two sets of range-of-motion measurements, both were invalid and he therefore disregarded the flexion range-of-motion measurements. Dr. Hall also performed two sets of range-of-motion measurements in February 2009 and those were invalid. Surveillance was conducted on the Claimant and showed the Claimant bending greater than Dr. Rook's

testimony that Claimant could only bend marsh 25°. The video surveillance showed the Claimant bending between 60-90° for a sustained period of time. Dr. Rook's impairment rating for the flexion range of motion was twice that provided by Dr. Castrejon. All other range-of-motion testing by all three physicians in extension, right and left lateral flexion and right and left rotation were almost identical.

7. Dr. Castrejon and Dr. Jenks testified that no further psychological treatment is reasonable and necessary. In addition, Dr. Castrejon testified that further counseling would exceed the Medical Treatment Guidelines. The ALJ credits these opinions above any other opinion. Claimant's treatment with Trudy Dawson is no longer reasonable or necessary.

ORDER

It is therefore ordered that:

1. Respondent shall admit for the 22% whole person impairment and pay benefits, subject to the $60,000 cap.

2. Claimant's treatment with Ms. Dawson is no longer reasonable or necessary and Respondents are not responsible for payment for any further treatment with Ms. Dawson.

3. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

4. All matters not determined herein are reserved for future determination.

DATE: July 29, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-608-694

ISSUES

The issues endorsed for hearing are Permanent Partial Disability (PPD) benefits and disfigurement.

FINDINGS OF FACT

The decision herein is based upon facts as stipulated to by the parties as follows:

1.The Claimant suffered an admitted lower back injury in 2004. He ultimately underwent L5-S1 spinal fusion surgery, but had persistent complaints. In May 2008, the Claimant underwent removal of fusion hardware and decompression of the left L5 nerve root.

2.Michael Dallenbach, M.D. is an Authorized Treating Provider (ATP).

3.Dr. Dallenbach found that the Claimant attained Maximum Medical Improvement (MMI) as of October 7, 2008 and assessed 32% whole person impairment.

4.Respondents filed a Final Admission of Liability (PAL) consistent with Dr. Dallenbach's MMI and impairment rating report.

5.Neither party contests the date of MMI or the impairment rating of Dr. Dallenbach.

6.The Claimant was 60 years of age at the time of MMI; therefore, the Claimant's Age Factor is 1.00.

7.The Claimant's Average Weekly Wage (AWW) qualifies him for the maximum compensation rate applicable for this date of injury, $674.59 per week.

8.The unadjusted PPD benefit amount is $86,347.52 ($674.59/week x 400 weeks x 32% x Age Factor 1.00).

9.The statutory PPD maximum payout rate is $361.99 per week.

10.The Claimant receives Social Security Disability Insurance (SSDI) benefits, in the original amount of $1,714.27 per month. This calculates to a Social Security offset of $197.80 per week.

11.The statutory cap on non-Permanent Total Disability benefits of $120,000 for the date of injury is implicated in this case. The Claimant has already been paid $98,369.99 of Temporary Total Disability (TTD) benefits.

12.The sole issue with respect to PPD is the *method* of calculation of the award in consideration of the statutory cap on indemnity benefits, the statutory cap on PPD payout rate, and the statutory offset of the SSDI award, specifically, the order in which these limits and offset apply.

13.At hearing,' the parties will request permission to file position statements to support their arguments as to the proper method of calculation of the PPD award.

The following facts were not stipulated to but are found by the ALJ:

14.Claimant suffered surgical scars to his stomach area consisting of a horizontal scar located six inches below Claimant’s navel area being ten inches

in length and one-quarter inch wide. On Claimant's back he has a surgical scar running vertically down the middle of the back being eighteen inches in length and three-quarters of an inch wide. Claimant is entitled to benefits for disfigurement.

CONCLUSIONS OF LAW

37. The parties both cite the *Armijo v. ICAO*, 989 P.2d 198 (Colo. App. 1999) case in support of their position; however, each interprets the results of that case differently. The issue in *Armijo*, was stated by the Court of Appeals as follows:

> The sole issue in this workers' compensation proceeding involves the proper method of calculating the offset for Social Security Disability Insurance (SSDI) benefits taken against permanent partial disability (PPD) benefits.

38. Thus, it is only the weekly payout formula that was calculated by the Court. In applying that formula the weekly offset amount is $197.80 as was stipulated to by the parties. The maximum weekly amount applicable is $361.99 as stipulated to by the parties. Thus, the weekly payment of PPD benefits is $164.19. ($361.99 - $197.80 = $164.19).
39. This formula reduces only the amount of benefits that can be received in any given week. It does not address the issue of the total amount of benefits payable. (To the extent that it may address that issue it would be *dicta* since that was not the issue before the Court.)
40. Claimant is entitled to $21,630.01, which is the difference between benefits received and the $120,000.00 cap that the parties agree is applicable.
41. Thus, the proper method to calculate the benefit is to take the $21,630.01 and to divide it by the weekly amount of PPD that is actually payable of $164.19. This gives the number of weeks over which the remainder of Claimant's PPD benefits are payable ($21,630.01 / 164.19 = 131.7377 weeks).
42. Claimant has suffered a permanent disfigurement to the body normally exposed to public view entitling him to additional compensation. Section 8-42-108 C.R.S. (2008).

ORDER

It is therefore ordered that:

1. Respondents shall file a Final Admission of Liability consistent with payment of $164.19 over a period of 131.737 weeks, totaling no more than $21,630.01.
2. Claimant has suffered a permanent disfigurement to the body normally exposed to public view entitling him to an additional $1,500.00 in compensation. Claimant's date of injury was March 17, 2004.
3. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.
4. All matters not determined herein are reserved for future decision.

DATE: July 29, 2009

/s/ original signed by:

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-626

ISSUE

The issue for determination is whether Claimant waived coverage as an owner/corporate officer. If Claimant did not waive coverage, the issues also include compensability and liability for medical care.

FINDINGS OF FACT

1.Claimant, the owner and President of Employer, was injured on November 26, 2008, in the course and scope of employment. He suffered a fracture to his left foot and ankle. The treatment received by Claimant from Elk Avenue Medical Center, Gunnison Valley Hospital, and Dr. Patricia Chamberland was reasonable and necessary to cure or relieve Claimant from his compensable injury.

2.Claimant contacted Rief, a licensed insurance agent at The Insurance Center, to obtain workers' compensation insurance coverage for Employer on October 23, 2008. Claimant asked Rief to obtain workers' compensation insurance for Employer with Pinnacol Assurance. Rief testified at hearing that Claimant was in a hurry to obtain this coverage, that he wanted the policy written and finalized as quickly as possible.

3.Rief, on October 23, 2008, sent Claimant forms and requests for information necessary to obtain the insurance price quote and workers' compensation insurance. Claimant filled out the forms in his own hand. On the

information sheet found on page 4 of Respondents' Hearing Exhibit A, Claimant stated that he was the president of the company, and wrote he wished to be excluded from coverage under the workers' compensation policy that would be issued. Rief sent Claimant the documents found in Respondents' Hearing Exhibit A, pages 1 and 3 through 9, on October 23, 2008. Claimant filled out those forms on October 23, 2008.

4.Claimant signed the Rejection of Coverage by Corporate Officers or Members of a Limited Liability Company, Part B/Individual Officer/LLC Member Questionnaire, found on page 9 of Respondents' Hearing Exhibit A. Claimant, in his own hand, checked the box stating that he elected to reject workers' compensation coverage for himself as a corporate officer, the President of Employer. In that form, he stated his duties for the corporation were as project manager.

5.Claimant understood that by signing the Rejection of Coverage by Corporate Officers or Members of a Limited Liability Company, Part B/Individual Officer/LLC Member Questionnaire he was rejecting coverage for himself. Claimant spoke with Rief and told her that he had filled out the forms and would send them back to her by fax. Claimant returned the signed and completed forms to Reif with directions to send them to Insurer to obtain workers' compensation insurance coverage for employer. Claimant never contacted Reif to tell her not to file the documents he had returned or that any of the statements he made in the documents were wrong or did not reflect his wishes. Claimant did appear before a notary to have the documents notarized.

6.Claimant, at the time he signed this rejection, intended to reject coverage and he intended to have the document notarized. Claimant told The Insurance Center he would notarize the Rejection of Coverage, Part B, found on page 9 of Respondents' Hearing Exhibit A. Claimant read the entire document and understood it. The document states that if the corporate officer later elects to change his election to reject coverage, a revised questionnaire must be filed. Claimant did not file any such revision with Insurer or The Insurance Center before Claimant's injury occurred.

7.Claimant, at a later date, decided he would not reject coverage for himself and wished to be covered under Insurer's workers' compensation insurance policy for Employer. Claimant did not sign any revised questionnaire or form documenting this decision. Claimant did not contact Insurer, Rief, or anyone at The Insurance Center to inform them that he had changed his mind and wished to be covered under the workers' compensation policy Employer had with Insurer. Claimant never told Rief not to submit the rejection of coverage forms to Insurer. Claimant did not make any attempt to revoke or amend that rejection and took no other steps to inform anyone that he wished to change his decision to reject coverage.

8.Claimant admitted that the signature on the Rejection of Coverage, Part

B, is his, and he signed it voluntarily, freely, and fully understanding that by signing the document he was electing to reject coverage with Insurer.

9.Rief received the documents from Claimant on October 24, 2008. She composed an Acord Workers' Compensation Application and submitted that application to Insurer on October 24, 2008. Claimant is listed as an individual to be excluded under the policy. This exclusion was consistent with Claimant's statements to Rief when he discussed the insurance policy with her. He stated that he wished to be excluded, and that he made the statements in the forms and the Rejection of Coverage by Corporate Officers or Members of a Limited Liability Company, Part B/Individual Officer/LLC Member Questionnaire. Claimant stated to Rief that he wished to be excluded from the workers' compensation insurance policy Insurer would issue for Employer. Rief submitted the insurance application to Insurer on October 24, 2008.

10.Insurer issued the workers' compensation insurance policy on October 29, 2008, with an effective date of October 25, 2008. Claimant admitted he received the Policy Information Page, and the insurance policy issued by Insurer after it was mailed on October 29, 2008. The policy was issued with the Endorsement: Rejected Corporate Officer From [sic] Coverage, found on page 21 of Respondents' Hearing Exhibit A, on October 29, 2008. At the bottom of the policy issued that day, found on pages 15 through 26 of Claimant's Hearing Exhibit 8, is a date and time stamp showing when the policy documents were printed. The policy and the Endorsement: Rejected Corporate Officer From [sic] Coverage documents were printed at the same time by Insurer. They were mailed together to Claimant/Employer and The Insurance Center. The documents were not returned as undeliverable to Insurer. Rief received the policy with the Endorsement: Rejected Corporate Officer From Coverage form from Insurer. This document shows that the policy was amended to show that Claimant as a corporate officer rejected coverage with Insurer. The claim notes maintained by Insurer show that the policy issued by Insurer on October 29, 2008, contained a signed rejection form.

11.Claimant's testimony that he did not receive the Rejected Corporate Officer From Coverage form before the date of the injury is not credible.

12.The Rejected Corporate Officer From Coverage endorsement was mailed with the policy, was printed with the policy, and would be mailed automatically with the policy to the insurance agent and Employer/Claimant. Claimant was excluded from the workers' compensation insurance policy written and issued by Insurer for Employer. At no time was Claimant covered by the policy before or at the time of his injury alleged in this claim. There were no documents filed before Claimant's alleged injury revoking or attempting to revoke Claimant's election to reject coverage. Neither Claimant nor any other person ever contacted Insurer to request that his rejection be changed before his alleged injury happened.

13.On November 26, 2008, Claimant sustained the compensable injury and received medical care.

14.On December 1, 2008, Ramirez, the claim representative assigned to Claimant's claim at Insurer, was reviewing Claimant's claim for compensation when she noted Claimant had rejected coverage. Ramirez contacted Cao that same day to ask whether this rejection was accurate. Cao reviewed the file and saw Claimant's insurance application and rejection of coverage statement. She found that Claimant clearly rejected coverage for himself in the workers' compensation policy issued by Insurer for Employer. Cao discussed this rejection with Claimant on December 8, 2008. Cao explained to Claimant that he had rejected the coverage. Cao explained to Claimant that if he were covered there would have been a much larger payroll used to calculate Claimant's insurance premium. The policy covered only one employee with a payroll of $21,000 a year, far less than the $47,000 in payroll that would have been used had Claimant been covered under the policy. This low payroll was used to calculate the premium charged to Employer on the insurance application excluding Claimant from coverage when the policy was issued on October 29, 2008.

15.Claimant did not say he had not rejected coverage during the conversation with Cao on December 8, 2008. Claimant did not state that the rejection was wrong, that her information was incorrect, or that he should have been covered. Claimant did not dispute the statement that he was not covered.

16.Insurer's policy is that to reject insurance coverage a signed Rejection of Coverage by Corporate Officers or Members of Limited Liability Company, Part B is necessary. The document signed by Claimant found on page 9 of Respondents' Hearing Exhibit A, by itself was all that was necessary to show Claimant rejected coverage for himself. Insurer has no requirement to have Part A of the Rejection of Coverage document to reject coverage. Part A is for informational purposes only, to show the identity of the company and the person electing to reject coverage. If only Part B is received, it would be accepted by Insurer.

17.Insurer's policy is that Part B need not be notarized to be accepted and binding. The rejection of coverage can be done without a notary signature to Part B of the rejection document. If Insurer had received page 9 of Respondents' Hearing Exhibit A without the notary signature and seal and only with Claimant's signature and the date of the signature, Insurer would have processed the application for insurance and issued the workers' compensation policy for Employer showing Claimant rejected coverage. Claimant rejected coverage for himself when he applied for workers' compensation insurance for Employer with Insurer.

CONCLUSIONS OF LAW

1. A corporate officer may reject workers' compensation coverage under the corporation's insurance policy. Section 8-41-202, C.R.S. Insurer has the burden of proof to show that the corporate officer rejected coverage.

2. "It is the general rule of law that it is the court's duty to construe an instrument so as to effectuate the manifest intentions of the parties." Neves v. Potter, 769 P.2d 1047, 1053 (Colo. 1989) (citations omitted). "The intentions of the parties as determined by the court shall rest on good sense and plain understanding of the words used and acts directed to be performed." *Id.* (citations omitted). When the document, "[I]s unambiguous and clear, resort may not be had to any extrinsic source, even if that source sheds light on the parties' intent." *Id.* (citations omitted). "[A]n unambiguous document must be interpreted based only upon the information contained within its four corners[.]" *Id.* at 1054. The trial court may only consider parole evidence, "[T]o vary or contradict the document when the litigation is between a party and a stranger thereto." *Id.* (citations omitted). The words and phrases used in a release should be interpreted by the trial court not in isolation, but by examination of the release as a whole. Roemmich v. Lutheran Hosp. & Home Soc. of Am., 934 P.2d 873, 875 (Colo.App. 1997).

3. "Whether a written contract is ambiguous and, if not, how the unambiguous contractual language should be interpreted, are questions of law …." Kaiser v. Discount Square Market Liquors, Inc., 992 P.2d 636, 640 (Colo.App. 1999), *cert. denied* (2000). A contract is ambiguous only if it is fairly susceptible of more than one interpretation." *Id*. When construing an unambiguous contract, the court may not rewrite its terms but must instead enforce it as written." *Id.* "Interpretation of a settlement agreement is a question of law, and the agreement must be enforced as written." Moland v. Industrial Claims Appeal Office, 111 P.3d 507, 510 (Colo.App. 2004).

4. "Moreover, a contract should never be interpreted to yield an absurd result." Atmel Corp. v. Vitesse Semiconductor Corp., 30 P.3d 789, 793 (Colo.App. 2001), *cert. denied*. "Strained construction of contract terms should be avoided." Continental Western Ins. Co. v. Heritage Estates Mut. Housing Ass'n, Inc., 77 P.2d 911, 913 (Colo.App. 2003); *see also* Allen v. Pacheco, 71 P.3d 375, 378 (Colo. 2003), *reh'g denied*. A court, "[M]ust construe the terms of the agreement in a manner that allows each party to receive the benefit of the bargain, and the scope of the agreement must faithfully reflect the reasonable expectations of the parties." Allen, 71 P.3d at 378.

If the words of an insurance policy are not ambiguous, they should be given their plain and ordinary meaning, unless the parties expressly intended an

alternative interpretation. *Id.* If a contractual provision is reasonably susceptible of different meanings, it must be construed in favor of providing coverage to the insured. Compass Ins. Co. v. City of Littleton, 984 P.2d 606, 613 (Colo.1999). (citing Chacon v. Am. Family Mut. Ins. Co., 788 P.2d 748, 750 (Colo.1990)) However, a mere disagreement between the parties regarding the meaning of a policy term does not create an ambiguity. State Farm Mut. Auto. Ins. Co. v. Stein, 940 P.2d 384, 387 (Colo.1997).

5. Although coverage provisions in an insurance policy are liberally construed in favor of the insured, courts should be wary of rewriting provisions. Fire Ins. Exch. v. Bentley, 953 P.2d 1297, 1300 (Colo.App. 1998). "Courts may neither add provisions to extend coverage beyond that contracted for, nor delete them to limit coverage." Cyprus Amax Minerals Co. v. Lexington Ins. Co., 74 P.3d 294, 299 (Colo.2003).

6. The propriety of the notary stamp and signature in this claim is not relevant, for Claimant admits signing the rejection of coverage form intending at that time to reject coverage for himself. "In reaching our conclusions, we recognize the claimant's contention that the employment agreements were invalid because his signature was not notarized in his presence. However, the record supports the ALJ's finding that the claimant admitted he signed the agreements. Under these circumstances, we agree with the ALJ that the circumstances of the notarization are immaterial." Fleming v. Judson Enterprises, W. C. No. 4-415-781 (ICAO, June 15, 2001).

7. Insurer has shown by a preponderance of the evidence that Claimant rejected coverage for himself when he applied for, obtained, and received workers' compensation insurance from Insurer for Employer. Claimant's intent was clearly manifested when he signed the rejection of coverage, Part B, form. Claimant signed this document, and at the time he signed it, understood that he would not be covered under the workers' compensation policy Insurer would issue for Employer based on his application. When Claimant signed the document, he fully intended the document to be notarized. There was no ambiguity in the document's language. Claimant read the rejection of coverage form fully, and understood its contents, when he signed the document. He returned the document to Rief with the other forms required for Employer's insurance application with Insurer so she could use them to obtain workers' compensation coverage for Employer with Insurer. Before his injury in this claim occurred, Claimant did not contact Insurer, Reif, or The Insurance Center to state he wished to rescind or alter his rejection of coverage.

8. Claimant's rejection of coverage was effective without a notary signature. The notary form, designed to verify that the signature is from the person purporting to sign the document, is not relevant in this claim, as Claimant admits he signed the Rejection of Coverage form, part B. The only document

required by Insuer for a valid rejection of coverage by a corporate officer such as Claimant is Part B of the rejection of coverage. The notary is not necessary for the document to be effective.

9. Claimant, at the time he signed the rejection of coverage form, intended to notarize the document and intended the rejection to be valid. Claimant did not rescind his rejection, or take any step to rescind his rejection of coverage before his injury. Claimant did not contact Rief or anyone at The Insurance Center to state he wished to change his prior rejection. Claimant did not contact anyone at Insurer to state he wished to change his prior rejection. Claimant admitted that he filled out the information required to submit an application for workers' compensation insurance for Employer to The Insurance Center and stated that he wished to be excluded from coverage under the policy.

10. Had Claimant wished to be covered under the workers' compensation policy, knowing that he had signed and returned the Rejection of Coverage, Part B, form to Reif, and knowing that he had told Reif in his conversation with her and in the forms he filled out for workers' compensation insurance for Employer that he wished to be excluded from coverage, he was required to contacted Insurer, Reif, or anyone at The Insurance Center, to see if his rejection had been submitted and whether the policy was written with him rejecting coverage for himself. Claimant took no step to do so and only took steps to discuss this rejection with Insurer after his November 26, 2008, fall.

11. Claimant's testimony that he did not receive the endorsement, found on page 21 of Respondents' Hearing Exhibit A, showing Claimant had rejected coverage as a corporate officer, is not credible. This document was printed and issued by Insurer at the same time as the Policy Information Page, the policy itself, and statements about the policy premium. Claimant received the insurance policy sent to him on October 29, 2008, by Insurer. Rief testified credibly that the endorsement showing Claimant rejected coverage was included in that policy she received. Cao testified credibly that identical policies were printed and issued to both The Insurance Center and Claimant by Insurer on October 29, 2008.

12. There is no legal requirement that a notary notarize the rejection of coverage form. There is no statute or rule stating the rejection of coverage form must be notarized. Cao explained that Insurer would and does accept rejection of coverage forms from corporate and LLC officers and members that are not notarized. Claimant admits he signed the Rejection of Coverage Election form on page 9 of Respondents' Hearing Exhibit A. Because that document was signed by Claimant and is unambiguous, clear, and definitive on its face, and because Claimant stated he read and understood that document, the Judge does not need to resort to extrinsic evidence in other documents, other evidence, or delve into Claimant's state of mind to ascertain Claimant intended to reject coverage for himself when he applied for and obtained workers' compensation

insurance for Employer with Insurer. However, extrinsic evidence, such as Claimant's hearing testimony, the testimony of Cao, the testimony of Reif, and the hearing exhibits such as page 4 of Respondents' Hearing Exhibit A, show Claimant rejected workers' compensation coverage with Insurer and was not covered by insurer's workers' compensation policy for employer on November 26, 2008.

ORDER

It is therefore ordered that Insurer is not liable for compensation and benefits in this claim because Claimant rejected coverage pursuant to Section 8-41-202, C.R.S.

DATED: *July 29, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-727-671

ISSUES

Whether Claimant's claim closed as to the issue of disfigurement pursuant to a final admission of liability (FAL) filed on July 8, 2008, which would preclude a disfigurement award entered on April 8, 2009.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. On May 11, 2009, the Office of Administrative Courts mailed a Notice of Hearing to Claimant at 2961 E. 110th Drive, Northglenn, CO 80233. This is Claimant's last known address pursuant to a certified copy of the Division of Workers' Compensation (DOWC) file.

2. The Notice advised the Claimant that hearing was scheduled to begin at 8:30 a.m. on July 30, 2009. By 8:40 a.m., Claimant had not appeared so the hearing commenced in his absence.

3. Based upon a review of a certified copy of the DOWC file, Respondent filed a FAL on July 7, 2008. Respondents admitted to $0.00 for disfigurement which is tantamount to a denial of liability for such benefits.

4. Pursuant to § 8-43-203(2)(b)(II), C.R.S., Claimant was required to contest Respondent's FAL within 30 days of July 7, 2008, or the case would automatically close as to the issues admitted in the FAL. A review of the DOWC file, including the computer chronology screen, does not reflect that Claimant filed an objection to the FAL. As such, the Judge infers that Claimant did not timely object to the FAL.

5. On March 9, 2009, Claimant filed a Request for a Disfigurement Award and submitted photographs to the DOWC. There was no certificate of mailing attached to the request for disfigurement and therefore no way to verify if Claimant mailed a copy to Respondent. The Judge infers that Claimant did not mail a copy to Respondent.

6. Prehearing Administrative Law Judge, Sharon A. Fitzgerald, entered a Disfigurement Order on April 8, 2009, and mailed a copy to Respondent's third-party administrator, Gallagher Bassett Services Inc., and to the Claimant.

7. Respondent filed an application for hearing on April 21, 2009, requesting reconsideration of the Disfigurement Order dated April 8, 2009. Respondents timely preserved the right to challenge the disfigurement order.

8. Pursuant to OACRP 10.B. if an application for hearing is timely filed, the disfigurement award shall be withdrawn and vacated. The Disfigurement Order dated April 8, 2009, was automatically vacated by operation of OACRP 10.B.

9. This claim, including the issue of disfigurement, closed by operation of the FAL dated July 7, 2008. Thus, Claimant was not entitled to the disfigurement award entered on April 8, 2009.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge enters the following conclusions of law:

1. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P. 3d 385 (Colo. App. 2000).

2. Section 8-43-203(2)(b)(II), C.R.S., provides that a claimant's case shall automatically close as to issues admitted in a final admission of liability should the claimant fail to contest the final admission within thirty days of the date of the final admission. As found, Claimant failed to contest the FAL filed on July 8, 2008. Accordingly, Claimant's claim, including the issue of disfigurement, automatically closed pursuant to the FAL dated July 8, 2008. Because Claimant's claim was closed, he was not entitled to the disfigurement award entered on April 8, 2009.

ORDER

It is therefore ordered that:

1. The claim is closed pursuant to the Final Admission dated July 8, 2008.

2. Claimant's request for disfigurement is denied and dismissed.

DATED: July 30, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-783-889

ISSUES

The issues determined herein are compensability and authorization of medical treatment by the Wound Care Center. The parties stipulated that the treatment by Memorial Hospital, Emergency Medicine Specialists, Dr. Topper, Dr. Campbell, and Dr. Hackenberg was due to a medical emergency.

FINDINGS OF FACT

1. The employer is a temporary employment agency. Claimant worked for the employer as a day laborer.

2. On January 14, 2009, Claimant was assigned to work at the Colorado Springs landfill picking up loose trash. On that date, he reached into a yucca plant to pick up a five-dollar bill and scraped the back of his right hand. This scrape did not draw visible blood. Claimant characterized it as a small brush or scrape. Because claimant could not see blood, he did not characterize it as a scratch. Claimant did not report the injury to his employer at that time because it was such a minor incident.

3. Two days later, claimant developed swelling on the back of his right hand and reported this to Ms. Lee, a supervisor. He was told to report if it worsens. Claimant used disinfectant and Epsom salts on the hand.

4. On January 23, 2009, another employee informed Ms. Dinet that Claimant's hand was looking very bad and that he thought it was due to an injury at the landfill.

5. On January 23, 2009, Ms. Dinet and Ms. Lee took the Claimant to Memorial Hospital. Claimant gave a consistent history to the hospital physicians that he scraped the hand on a yucca plant at the landfill. Claimant was immediately admitted to Memorial Hospital and emergency surgery was done that evening to debride the infected wound.

6. Claimant remained in the hospital and underwent two more surgical debridements by Dr. Steven Topper in an attempt to save his limb. While in the hospital, Claimant was treated by Dr. Thomas Hackenberg, an infectious disease specialist. Claimant was on a pain pump and pain killers while he was in the hospital. On January 26, 2009, Dr. Campbell provided hyperbaric therapy due to a concern about possible anaerobic bacteria.

7. On January 29, 2009, Nurse Rudisill changed claimant's wound vacuum sponge. She ordered claimant to recheck with her on Mondays and with Dr. Jain at the Wound Healing Center on Thursdays.

8. On February 4, 2009, the insurer denied the workers' claim for compensation.

9. On February 12, 2009, Claimant was released home with a wound vacuum and ordered to follow up with the Memorial Hospital Wound Center for debridement and further intravenous antibiotic treatments.

10. On February 26, 2009, Dr. Topper performed another surgery to debride the wound.

11. On January 29, 2009, Ms. McGuire, the adjuster, conducted a telephone interview of claimant, who again reported that the yucca plant rubbed his hand, but did not draw any visible blood.

12. On April 14, 2009, Dr. Roth performed a medical record review for respondents. He concluded that the infection was not related to work activities because claimant had no break in the skin. Dr. Roth noted that the infection was not due to methicillin resistant staphylococcus aureus ("MRSA") bacteria, but was due to methicillin sensitive staphylococcus aureus bacteria, which is commonplace. Dr. Roth suggested that the infection was due to claimant's diabetes.

13. Dr. Hackenberg testified by deposition that the nature of the bacteria did not affect the causation determination; it simply increased the number of antibiotics that could be used to treat the infection. That testimony is

persuasive. When asked to review Dr. Roth's report and comment on it, Dr. Hackenberg strongly disagreed with Dr. Roth's conclusion that the infection was due to his diabetes and not his work. Dr. Hackenberg explained that a visible portal of entry for bacteria is unnecessary. He noted, however, that a known injury or visible portal of entry is a more likely source for the bacteria to enter the bloodstream. Dr. Hackenberg confidently concluded that the injury led to claimant's infectious disease. He explained that the staph bacterium is normally present on the skin of at least one-third of all people. The known portal of entry, such as any sort of trauma, greatly increases the likelihood of infection especially if the infection is in the area of the trauma. Dr. Hackenberg also explained that claimant's diabetes did not cause the infection, but it predisposed him to a disease and a more severe disease. Dr. Hackenberg further opined that to a reasonable degree of medical probability, if it had not been for that poke or injury to the back of his hand, the Claimant would not have had the infection. Dr. Hackenberg's testimony is credible and persuasive.

14. Claimant also had preexisting well-healed scars on his legs from injuries playing soccer. These scars were not the probable portals of entry for the bacteria.

15. Claimant has proven by a preponderance of the evidence that he suffered an injury arising out of and in the course of his employment on January 14, 2009. Claimant's testimony is credible. He scraped the back of his right hand while picking up a five-dollar bill in the course of his job duties of picking up loose trash at the landfill. The action of picking up the bill was an insignificant deviation from his assigned duties. Claimant gave a consistent history that he scraped the hand on a yucca plant at the landfill. The opinions of Dr. Hackenberg are persuasive that the methicillin sensitive staphylococcus aureus bacteria, which is present on the skin of one-third of all people, was given a portal to enter claimant's systems due to the yucca scrape. The bacterium is microscopic and a visible wound is not necessary for a portal. The fact that the infection occurred in the dorsum of the right hand further supports the finding that the portal for entry was made by the scrape at the landfill. Claimant's preexisting diabetes made him more susceptible to infection and to a more serious infection, but the diabetes did not cause the infection. Claimant's well-healed leg scars were not likely the source for the infection.

16. After the emergency ended, the insurer reasonably knew or should have known that claimant had a need for ongoing follow-up wound care, but respondents failed to refer claimant to any other providers. Claimant was referred to the Wound Care Center by the Memorial Hospital providers. On February 4, 2009, the insurer informed Memorial Hospital that the claim was denied. The insurer did not refer claimant to another provider. The care was clearly reasonably necessary. Indeed, claimant even had to undergo another wound debridement by Dr. Topper on February 26, 2009.

CONCLUSIONS OF LAW

1. As found, claimant has proven by a preponderance of the evidence that he suffered an injury arising out of and in the course of his employment on January 14, 2009. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). Respondents argue that claimant was on a personal deviation when the injury occurred. The issue is whether a deviation is substantial enough to break the chain of causation. *See Phillips Contracting, Inc. v. Hirst*, 905 P.2d 9 (Colo. App. 1995). When a personal deviation is asserted, the issue is whether the activity giving rise to the injury constituted a deviation from employment so substantial as to remove it from the employment relationship. *Silver Engineering Works, Inc. v. Simmons*, 180 Colo. 309, 505 P.2d 966 (1973); *Roache v. Industrial Commission*, 729 P.2d 991 (Colo.App.1986). It is sufficient if the injury arises out of a risk that is reasonably incidental to the conditions and circumstances of the particular employment. *Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). In this case, the act of picking up the five-dollar bill was an insignificant deviation from the Claimant's assigned duties and therefore does not remove it from the employment relationship.

2. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App.

1990). Furthermore, the claimant's need for emergency treatment does not affect the respondents' designation of the authorized treating physician for all non-emergency treatment. *Sims v. Industrial Claim Appeals Office, supra.* A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. Once an emergency has ended, the employee must give notice to the employer of the need for continuing medical service and the employer then has the right to select a physician. *Sims*, *supra*, 797 P.2d at 781. An employer is deemed notified of an injury when it has some knowledge of accompanying facts connecting the injury or illness with the employment and indicating to a reasonably conscientious manager that the case might involve a potential compensation claim. *Jones v. Adolph Coors Co.*, 689 P.2d 681, 684 (Colo. App. 1984). As found, after the emergency ended, the insurer reasonably knew or should have known that the Claimant had a need for ongoing follow-up wound care, but Respondents failed to refer Claimant to any other providers. Claimant was referred to the Wound Care Center by the Memorial Hospital providers. On February 4, 2009, the insurer informed Memorial Hospital that the claim was denied. The insurer did not refer the Claimant to another provider. The care was clearly reasonably necessary. Claimant even had to undergo another surgical wound debridement by Dr. Topper on February 26, 2009. The insurer shall pay for the treatment at the Wound Care Center.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for the January 14, 2009, injury, including the bills of Memorial Hospital, Emergency Medicine Specialists, Dr. Topper, Dr. Campbell, Dr. Hackenberg, and the Wound Care Center.

2. All matters not determined herein are reserved for future determination.

DATED: July 31, 2009

Martin D. Stuber
Administrative Law Judge

ISSUES

Whether Claimant has proven by a preponderance of the evidence that he is permanently totally disabled and entitled to PTD benefits.

Whether Claimant has proven by a preponderance of the evidence that medical treatment is needed after maximum medical improvement to maintain Claimant's condition.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as a Produce Clerk. Claimant sustained an injury to his low back on March 5, 2007 when he was stocking the backroom and lifted a 40-pound box overhead developing pain in the lower back.

2. Claimant was referred by Employer to Concentra Medical Center where he was examined on March 6, 2007 by Dr. James Fox, M.D. Dr. Fox diagnosed Claimant with lumbar strain, assigned work restrictions and prescribed medications.

3. Claimant was seen at Concentra on March 12, 2007 by Dr. Landers. At this time, Claimant's work restrictions were lessened to no lifting over 20 pounds, no pushing/pulling over 20 pounds and no prolonged standing/walking longer than tolerated.

4. Claimant's ATP, Dr. Fox, referred Claimant to Dr. Robert Kawasaki, M.D. for a physical medicine consultation. Dr. Kawasaki evaluated Claimant on November 1, 2007. Dr. Kawasaki obtained a history from Claimant that he had had chronic back pain since a bicycle/ motor vehicle accident in 1991 but had done well after surgery on his back in 2006 by Dr. Jatana.

5. Dr. John Burris, M.D. was also an ATP of Claimant through Concentra Medical Center. Dr. Burris referred Claimant to Dr. Scott Primack, D.O. and Dr. Primack evaluated Claimant on March 17, 2008. Claimant provided a history to Dr. Primack consistent with the history given to Dr. Kawasaki that he began experiencing chronic back pain in 1991 after the bicycle accident. Claimant dealt with the pain from 1991 through 2005 and was able to work. Claimant

had done well after the surgery with Dr. Jatana in January 2006 and was able to return to work full time.

6. Claimant underwent a psychological assessment by Dr. Suzanne Kenneally, PhD on April 15, 2008. Dr. Kenneally noted that Claimant was not napping during the day. The results of psychological tests administered by Dr. Kenneally showed Claimant to have an overly personalized and overly emotional reaction to illness or injury, including the translation of psychological distress into physical symtomatology. Claimant's profile on testing matched individuals whose pain experience was being negatively impacted and maintained by unconscious psychological processes.

7. Dr. Burris evaluated Claimant on May 15, 2008 and felt he was at MMI. Dr. Burris commented that Claimant's present complaints did not appear to have a physiologic basis based upon previous testing done. Dr. Burris noted concerns with Claimant's medication usage and stated that he would not be prescribing any further medications to Claimant. Dr Burris performed range of motion tests that fluctuated significantly between trials and were invalid. Dr. Burris referred Claimant for a Functional Capacity Evaluation.

8. A Functional Capacity Evaluation of Claimant was performed on June 10, 2008. Claimant told the evaluator that he spent 20 hours per day sleeping or lying, in contradiction to the information obtained by Dr. Kenneally at her evaluation in April 2008.

9. The results of the Functional Capacity Evaluation ("FCE") showed that Claimant is able to work at the light-medium physical demand level for an 8-hour day. The results of this FCE were borderline invalid due to poor effort on the part of Claimant based upon the results of validity tests used during the evaluation. Claimant passed 69% of the validity criteria placing Claimant in the category of poor effort and a borderline invalid test. According to the validity criteria used, had Claimant passed 70% of the validity criteria, his results would have been considered borderline valid and a conservative estimate of Claimant's physical capacity. The ALJ finds that Claimant's ability to perform work in the light-medium category for 8 hours per day represents Claimant's minimum work capability, rather than the maximum.

10. Dr. Burris evaluated Claimant on June 12, 2008 and placed him at MMI on that date. Dr. Burris again performed range of motion testing that failed validity criteria. Dr. Burris opined that no maintenance or follow-up care was required and released Claimant from his care.

11. Dr. John Barrett performed a DIME on November 25, 2008. Dr. Barrett noted that at the time of his evaluation Claimant was not taking any controlled medications. Dr. Barrett's diagnosis was pain syndrome with some anatomic correlates, coexisting with pain behaviors and chronicity that are non-anatomic and non-related to any past injury. Dr. Barrett opined that other services, procedures and modalities should be terminated. Dr. Barrett assigned Claimant 16% whole person impairment and felt Claimant did not have any limitations.

12. Dr. Robert Watson, M.D. is a Preventative and Occupational Medicine specialist. Dr. Watson performed an independent medical examination of Claimant at the request of Respondents and issued a report dated June 17, 2009. Dr. Watson obtained a history from Claimant that at the time of his evaluation Claimant was walking up to six blocks per day and was on the computer off and on during the day. Dr. Watson noted the results of the FCE and that they were borderline invalid. Dr. Watson opined, and it is found, that Claimant is likely able to do more than the FCE identified and that the FCE does not represent Claimant's actual ability.

13. Claimant was evaluated by Dr. Joseph Ramos, M.D. on March 2, 2009. Dr. Ramos assigned work restrictions of no lifting, pushing/pulling over 10-pounds, no repetitive bending or twisting at the waist, no repetitive lifting, squatting, kneeling or crawling; no walking greater than 30 minutes continuously, no standing or sitting greater than 1 hour at a time and no lifting overhead or away from the body. Dr. Ramos does not persuasively explain the basis or methodology utilized to obtain these restrictions. Dr. Ramos' report does not contain information regarding the results of any physical examination of Claimant. The ALJ finds Dr. Ramos' opinion as to Claimant's work restrictions not credible or persuasive.

14. Claimant is currently 55 years of age. Claimant possesses a high school education graduating in 1973. After high school, Claimant obtained a certification in welding from Colorado Welding School. Claimant then attended University of Colorado at Denver majoring in mechanical engineering for 2 ½ years with a 3.0 GPA at the time he left school. Claimant did not finish his schooling in mechanical engineering because he elected to seek full –time employment at King Soopers rather than remain a student.

15. Claimant was employed at King Soopers from 1976 through 1988 in jobs as a night crew foreman, produce, produce head clerk, as a checker and all-purpose clerk. From 1988 through 1996 Claimant worked as a real estate appraiser with certification through the State of Colorado. Beginning in 1994, Claimant worked part-time for Super K-Mart as a produce clerk. Claimant began full-time work

for Super K-Mart in 1996 after leaving the real estate business, and Claimant ultimately became an assistant produce manager. Claimant left Super K-Mart in 2006 and began employment as a produce clerk with Employer. For the first five months of his employment with Employer, Claimant ran the produce department, then reduced his work to part-time hours.

16. Katie Montoya, a vocational expert, performed a vocational assessment of Claimant and interviewed Claimant on May 13, 2009. Based upon the information provided by Claimant to Ms. Montoya, the ALJ finds that Claimant plays on the computer, surfs the internet, is able to use the computer to search for jobs on-line and to submit employment applications on-line. Claimant described himself to Ms. Montoya, and it is found, as being a beginner to intermediate computer user.

17. Ms. Montoya opined, and it is found, that Claimant has ongoing transferable skills including contact with customers that will continue to benefit Claimant. Ms. Montoya performed vocational research using work restrictions placing Claimant generally in a light duty category. The results of this vocational research show that Claimant continues to have the ability to perform jobs available in the local labor market as described by Ms. Montoya. Ms. Montoya opined, and it is found, that Claimant continues to maintain the ability to work and earn a wage. The opinions of Ms. Montoya concerning the Claimant's employability and ability to earn a wage are found to be credible and persuasive.

18. John Macurak, a vocational expert, also performed a vocational assessment of Claimant. Mr. Macurak conducted a transferable skills review based upon Claimant being able to perform work in the "modified sedentary-light' category of work demand. Mr. Macurak's use of this work category is not persuasive as it represents a restriction upon Claimant's physical ability to work that is less than Claimant's actual ability. As found, Claimant has the physical ability to work at above the "modified sedentary-light" category used by Mr. Macurak.

19. Mr. Macurak opined that Claimant would not be able to qualify for jobs such as cashier, sales clerk, administrative clerk, and hotel clerk because these occupations were beyond Claimant's physical ability and because Claimant lacks experience in computer operation. Mr. Macurak's opinion is not persuasive as the basis for the opinion is rebutted by the results of the FCE and the fact that Claimant has more computer skills than assessed by Mr. Macurak. In support of his opinions. Mr. Macurak attached to his report an analysis of the job of Stock Clerks, Sales Floor. This analysis states that no

previous work experience is needed for such jobs and that training is provided by experienced workers on-the-job. Mr. Macurak noted in his report research into the job of Stock Clerk indicated that training on the use of automated equipment is usually done informally, on the job. Related occupations to Stock Clerk, based upon Mr. Macurak's research, included Food Preparation workers, Cashiers, Counter and Retail Clerks, jobs similar to those considered by Ms. Montoya in her assessment. Mr. Macurak opined that Claimant would not qualify for customer service jobs because he has no background in this area. This opinion is directly inconsistent with Claimant's work history as a real estate appraiser, produce clerk and manager of a produce department where it would be usual for Claimant to come in contact with customers and assist them. The ALJ finds that Mr. Macurak's opinion that Claimant is unable to earn a wage is not credible or persuasive.

20. Claimant has failed to prove by a preponderance of the evidence that Claimant is unable to earn a wage and that he is permanently totally disabled.

21. The ALJ resolves the conflict between the opinions of Dr. Burris, Dr. Barrett and Dr. Ramos regarding the need for medical treatment to maintain Claimant's condition after MMI in favor of the opinions of Dr. Burris and Dr. Barrett as being more credible and persuasive.

22. Claimant has failed to prove by a preponderance of the evidence that medical treatment is reasonable needed to maintain Claimant's condition after the date of MMI.

CONCLUSIONS OF LAW

I.

GENERAL

23. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the

evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

24. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

1. **II.**

2. **THE STANDARD FOR PERMANENT TOTAL DISABILITY**

25. Under the applicable law, claimant is permanently and totally disabled if he is unable to "earn any wages in the same or other employment." Section 8-40-201(16.5)(a), C.R.S. Under this statute, claimant is not permanently and totally disabled if he is able to earn some wages in modified or part-time employment. *McKinney v. Industrial Claim Appeals Office*, 894 P.2d 42 (Colo. App. 1995).

26. In determining whether the claimant is unable to earn any wages, the ALJ may consider a number of "human factors." *Christie v. Coors Transportation Co*., 933 P.2d 1330 (Colo. 1997). These factors include the claimant's physical condition, mental ability, age, employment history, education and the "availability of work" the claimant can perform. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). Another human factor is the claimant's ability to obtain and maintain employment within his physical abilities. *See Professional Fire Protection, Inc. v. Long*, 867 P.2d 175 (Colo. App. 1993). This is because the ability to earn wages inherently includes consideration of whether the claimant is capable of getting hired and sustaining employment. *See Christie v. Coors Transportation Co*., *Supra*; *Cotton v. Econ. Lub-N-Tune*, W.C. No. 4-220-395 (Jan. 16, 1997), *Affirmed Econ. Lub-N-Tune v. Cotton* (Colo. App. No. 97CA0193, July 17, 1997). The test for determining the "availability of work" is whether employment exists "that is reasonably available to claimant under his or her particular circumstances." *Christie, Supra; Weld County School District, Supra*.

27. The overall objective of this standard is to determine whether, in view of all the other factors, employment is "reasonably available to the claimant under his or her particular circumstances." *Weld County School District RE-12 v. Bymer*, supra. Respondents are not required to prove the existence of a particular job, which a particular employer has made available to the claimant. *James V. Wetherfred, Affirmed v. Industrial Claim Appeals Office* (Colo. App. No.

96CA0275, Sept. 5, 1996) (not selected for publication). Rather, it is the claimant's burden to prove he is unable to obtain and sustain employment where he can earn wages. Section 8-40-201(16.5)(a), C.R.S.. The question of whether the claimant has met this burden by a preponderance of the evidence is factual in nature.

28. As found, Claimant has failed to prove by a preponderance of the evidence that he is unable to earn a wage and is permanently totally disabled. The opinions of Mr. Macurak in support of Claimant's claim are not persuasive for the reasons found above. Mr. Macurak relies upon an overly restrictive assessment of Claimant's physical abilities for his opinion. Mr. Macurak's opinion excluding Claimant from customer service type jobs substantially conflicts with Claimant's demonstrated work history. That Claimant may have difficulty competing for some jobs in the current labor market is not considered persuasive to show that Claimant is unable to earn any wage. Although Claimant continues to have back pain, Claimant has previously been able to work even though he had chronic back pain. Claimant has significant past work experience and education that provides him with transferable skills into occupations that are available in the local labor market and provide Claimant the ability to earn a wage. The research, analysis and opinions of Ms. Montoya are persuasive and support the finding and conclusion that Claimant remains able to earn a wage within his education, work experience and physical ability.

III.

LIABILITY FOR MEDICAL TREATMENT AFTER MMI

29. The need for medical treatment may extend beyond the point of maximum medical improvement where claimant presents substantial evidence that future medical treatment will be reasonably necessary to relieve the effects of the injury or to prevent further deterioration of his condition. *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609 (Colo. App. 1995). An award for *Grover* medical benefits is neither contingent upon a finding that a specific course of treatment has been recommended nor a finding that claimant is actually receiving medical treatment. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 992 P. 2d 701 (Colo. App. 1999). The claimant must prove entitlement to *Grover* medical benefits by a preponderance of the evidence. *Lerner v. Wal-Mart Stores, Inc.,* 865 P.2d 915 (Colo. App. 1993). An award of *Grover* medical benefits should be general in nature, subject to Respondents' right to contest compensability, reasonableness and necessity. *Hanna v. Print Expediters Inc.,* 77 P.3d 863 (Colo. App. 2003).

30. The opinion of Dr. Ramos concerning the Claimant's need for medical treatment to maintain his condition after MMI is not persuasive. Dr. Ramos provides no persuasive rationale for his opinion that Claimant is in need

of significant medical treatment and medications after MMI. Dr. Ramos' opinion on Claimant's need for medications is contrary to the opinion of the ATP and the records that have noted significant problems associated with Claimant's use of medications for pain. As testified and opined by Dr. Watson, Dr. Ramos' suggestion that Claimant should use the services of emergency rooms to obtain pain medications is inconsistent with Division of Workers' Compensation Medical Treatment Guidelines and accepted standards of medical care. The ALJ concludes and finds that Dr. Ramos' opinion on the need for medical care after MMI is not persuasive. The more persuasive opinions are those of Dr. Burris, an ATP, and Dr. Barrett, the DIME physician, both of whom found that Claimant is not in need of any further treatment after MMI. Claimant's testimony that he wants treatment and medications for pain is not considered persuasive to establish the need for such treatment after MMI. Claimant has failed to prove by a preponderance of the evidence that medical treatment is necessary after MMI to relieve the effects of the injury, to maintain Claimant's condition or to prevent deterioration of Claimant's condition.

ORDER

It is therefore ordered that:

1. Claimant's claim for permanent total disability is denied and dismissed.

2. Claimant's claim for medical treatment after MMI is denied and dismissed.

DATED: July 31, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-732-329

PROCEDURAL BACKGROUND

Hearings in this matter were held before Administrative Law Judge Peter J. Cannici on March 6, 2008, May 9, 2008 and September 19, 2008 at the Office of Administrative Courts in Denver, Colorado. Claimant was represented by Ken R. Daniels, Esq. Respondent Gerardo Montanez Drywall appeared on his own behalf. Respondents Wetherbee Drywall and Pinnacol Assurance were

represented by Thomas M. Stern, Esq. The proceedings on March 6, 2008 were digitally recorded in the Grand Mesa Courtroom from 3:15 p.m. until 4:59 p.m. The proceedings on May 9, 2008 were digitally recorded in the Grand Mesa Courtroom from 8:43 a.m. until 4:53 p.m. The proceedings on September 19, 2008 were digitally recorded in the Grand Mesa Courtroom from 8:34 a.m. until 11:13 a.m. The Judge held the record open until October 20, 2008 to allow the parties to submit position statements.

On November 10, 2008 ALJ Cannici issued Findings of Fact, Conclusions of Law and Order (Order) in this matter. The Order concluded that Claimant worked for GMD as an independent contractor and that he was free from direction and control in the performance of his drywall-finishing duties. ALJ Cannici thus denied and dismissed Claimant's request for Workers' Compensation benefits.

Claimant appealed the Order. He asserted that the record lacked substantial evidence to support ALJ Cannici's determination that he was an independent contractor at the time he was injured on July 2, 2007. On April 28, 2009 the Industrial Claim Appeals Office (Panel) rejected Claimant's assertion. The Panel determined that the record supported ALJ Cannici's resolution of the factual issues enumerated in §8-40-202(2)(a), C.R.S. regarding whether Claimant was free from direction and control in the performance of his duties and was customarily engaged in an independent trade or business related to drywall services. However, the Panel noted that ALJ Cannici did not resolve an evidentiary conflict about whether Claimant "actually provided similar services to others sufficient to establish an independent trade, occupation, profession or business." The Panel thus set aside the Order and remanded the matter for entry of a new order on whether Claimant "worked as an independent contractor after resolution of the conflict in the evidence of whether [Claimant] actually and customarily provided similar services to others."

ISSUE

Whether GMD has established by a preponderance of the evidence that Claimant actually and customarily provided drywall-finishing services to others and was an "independent contractor" pursuant to §8-40-202(2) C.R.S.

FINDINGS OF FACT ON REMAND

1. Claimant is a 34-year old male who has been working as a drywall finisher since 1998. He is a skilled drywall finisher who does not require training or supervision.

2. Angel Salgado owned and operated a company known as Drywall Services from 1997 until the business went bankrupt in the middle of 2007. Mr. Salgado estimated that approximately 90% of the workers used by Drywall

Services were subcontractors or independent contractors. Mr. Salgado first met Claimant in approximately 2002 when Claimant was recommended to him as a great drywall finisher.

3. Claimant performed drywall work for Drywall Services for at least two years. During that time, Claimant used his own tools and had his own transportation. Claimant did not require training or supervision to ensure the quality of his work. Claimant was the crew leader of a group that consisted of his two brothers. Drywall Services paid Claimant by checks made payable in his name. The checks covered work performed by Claimant and his brothers. At the bottom of each check, Mr. Salgado wrote "contract labor." Mr. Salgado considered Claimant to be an employee of Drywall Services because Claimant did not have a trade name.

4. In contrast, Insurer's Investigator Nino Santiago interviewed Mr. Salgado. Mr. Salgado told Mr. Santiago that Claimant was not his employee and that Claimant worked for Drywall Services as a subcontractor. Mr. Salgado also told Mr. Santiago that Claimant did not work exclusively for Drywall Services and worked as a subcontractor for others.

5. During part of 2006 Claimant worked as a drywall subcontractor for a company owned by Lorenzo Montanez (L. Montanez) known as Durango Drywall. At the same time, Gerardo Montanez (G. Montanez) worked for Amigos Drywall as a supervisor and a "go-between" with subcontractors. L. Montanez is the uncle of G. Montanez.

6. In late 2006 Amigos Drywall sought to hire another drywall finisher. G. Montanez thus contacted L. Montanez and inquired whether any of Durango Drywall's drywall finisher subcontractors needed work. Claimant was the first subcontractor that L. Montanez identified. G. Montanez thus called Claimant to discuss whether he was interested in subcontracting drywall work from Amigos Drywall. G. Montanez explained that he was looking for someone to do contract work. Claimant responded that he was finishing a home for Mr. Salgado but that he could start as soon as he was done with that house. G. Montanez thus offered Claimant work on a house.

7. While Claimant was working on the first house for Amigos Drywall, G. Montanez inquired whether Claimant would be willing to undertake additional work. Claimant accepted additional work and brought a crew consisting of Martin Valdez, Manuel Portillo and Natividad Ontiveros to work with him.

8. In early February 2007 G. Montanez separated from Amigos Drywall and began GMD as his own drywall company. G. Montanez dealt directly with Claimant on all business issues. Although Claimant's crew helped him with projects, G. Montanez did not directly hire Claimant's crew.

9. From its inception, GMD subcontracted drywall work from WD. GMD, in turn, subcontracted various phases of drywall work to subcontractors. GMD has had as many as four or five drywall finisher subcontractors working on houses at one time and as many as four or five drywall hanger subcontractors working at one time.

10. GMD does not have employees and handles all of its subcontractors in the same manner. It pays subcontractors by check and does not withhold taxes. At the end of the year GMD issues its subcontractors 1099 forms. GMD does not pay its subcontractors an hourly rate, but instead pays its drywall finishers per sheet of drywall. The subcontractors also provide their own tools. GMD does not require its subcontractors to work exclusively for GMD, but instead permits them to work for other contractors at the same time.

11. GMD notifies its drywall finishers of a completion or texture date but does not provide a work schedule. GMD does not tell its subcontractors what days of the week to work, when to arrive at work, when to leave work or when to take breaks. GMD also does not track its subcontractors' hours.

12. WD is a drywall business that receives subcontracting work from general contractors or builders. The general contractor or builder hires WD to perform drywall services on houses, town homes and hotels. Although WD has some employees, it often subcontracts work to various subcontractors. WD subcontracted drywalling work to GMD. GMD not only received subcontracting work from WD, but G. Montanez also worked as an employee for WD. GMD then subcontracted some of the drywall finishing work to Claimant.

13. During the time that Claimant performed work for GMD he used his own work van and supplied his own tools. However, because he did not have his own taping bazooka, GMD rented a taping bazooka to Claimant. Moreover, WD provided Claimant and other subcontractors with materials to complete their projects.

14. GMD did not train Claimant in performing drywall-finishing work and Claimant required little supervision. However, G. Montanez regularly inspected Claimant's work to ensure that it satisfied contract and builder specifications. Moreover, WD supervisor Jeffrey Kirk also reviewed the quality of drywall projects. If drywall-finishing projects were unsatisfactory, Mr. Kirk would contact G. Montanez to inform him that the projects did not meet standards. G. Montanez then contacted Claimant and Claimant remedied any deficiencies in the projects.

15. GMD paid Claimant by the sheet of finished drywall. GMD paid Claimant with a personal check because Claimant did not have a company name. GMD did not withhold any taxes from Claimant's pay and did not provide him with any benefits. Claimant then distributed the money that he received from

GMD to the members of his work crew. GMD did not otherwise combine its business operations with Claimant's operations.

16. After Claimant received a house that required drywall-finishing work, GMD provided Claimant with a texture or completion date. The texture or completion date is the date on which the builder has mandated completion of the drywall phase of the project. G. Montanez and Mr. Kirk required the projects to be completed by the texture date. However, Claimant was not required to work a fixed schedule. He was permitted to set his own hours, take breaks as he pleased and work as many days each week as he desired as long as he completed the project on time.

17. Although Claimant's crewmembers testified that they did not undertake additional projects while working for GMD, the record reveals that Claimant actually and customarily provided similar drywall-finishing services to others. G. Montanez testified that during the period Claimant worked for him, Claimant continued to work for Mr. Salgado and others in Denver, Colorado Springs, and Pueblo. On several occasions G. Montanez checked on houses that he had subcontracted to Claimant for drywall finishing but Claimant and his crew were not at the houses. There were also several times when Mr. Kirk stopped by houses where Claimant was supposed to be working, but Claimant was not present. On several occasions, Mr. Kirk asked G. Montanez about Claimant's location, and G. Montanez notified Mr. Kirk that Claimant was working on someone else's project. G. Montanez remarked that he was not concerned about whether Claimant was working on another contractor's house because Claimant was free to come and go as he pleased as long as he completed his assigned projects.

18. On July 2, 2007 Claimant was working on a house that GMD had subcontracted from WD. Claimant was walking on stilts taping drywall when he tripped over a piece of sheetrock. Martin Valdez and G. Montanez transported Claimant to the hospital. Claimant sustained a right patellar fracture as a result of the incident. On July 6, 2007 he underwent surgery to repair the fracture.

19. Shortly before Claimant began working on the house where he was injured, he performed work for Mr. Salgado on a house on Old Ranch Road in Colorado Springs. G. Montanez testified that he spoke to Claimant about working on another house and Claimant replied that he had to quickly complete drywall work on a house for Mr. Salgado. Approximately one week after the conversation G. Montanez contacted Claimant about delivering a check for prior work that Claimant had performed. Claimant asked G. Montanez to deliver his check to the house that he was "touching up" for Mr. Salgado on Old Ranch Road. When G. Montanez pulled up to the house on Old Ranch Road, he observed Claimant's work van. G. Montanez then called Claimant on his cell phone to let him know he was outside with the check. When Claimant answered, he stated that he was currently working on stilts and was busy because the

drywall work needed to be completed right away. G. Montanez then told Claimant he would leave his check in his work van.

20. Claimant only worked for GMD between February 2007 and July 2, 2007. During the time Claimant worked for GMD he performed similar services for at least one other subcontractor. The evidence also reveals that during the two-year period preceding his work injury Claimant moved from one contractor to the next when work slowed down or when a subsequent contractor could offer him more steady work.

21. GMD has demonstrated that it is more probably true than not that Claimant worked for it as an independent contractor and that he was free from direction and control in the performance of his drywall-finishing duties.

22. Two factors weigh against concluding that Claimant worked as an independent contractor for GMD. First, Claimant received personal checks from GMD because he did not have a trade name. Claimant then divided the checks with other members of his work crew. Furthermore, GMD has failed to produce sufficient evidence that it could terminate its relationship with Claimant without liability.

23. However, the overwhelming majority of factors suggest that Claimant worked as an independent contractor for GMD. Initially, GMD did not combine its business with Claimant's business. Moreover, during the time that Claimant performed work for GMD he used his own work van and supplied his own tools. Moreover, although GMD supplied Claimant with a taping bazooka, Claimant was required to rent the machine from GMD. Renting a piece of equipment to an individual is not consistent with an employer-employee relationship.

24. GMD did not provide any training to Claimant regarding drywall-finishing work and Claimant required little supervision. Claimant had significant drywall experience and was a skilled drywall finisher.

25. GMD did not dictate a quality standard for Claimant's work. Although G. Montanez and Mr. Kirk ensured that Claimant's work satisfied contract and builder specifications, they did not oversee Claimant's actual work or instruct Claimant on proper drywall finishing.

26. GMD paid Claimant by the sheet of drywall that he finished. Claimant did not receive an hourly rate for his work.

27. GMD did not dictate the time of performance for Claimant's drywall finishing. GMD provided Claimant with a texture or completion date. The texture or completion date is the date on which the builder has mandated completion of the drywall phase of the house. Claimant was thus not required to work a fixed schedule. He was permitted to set his own hours, take breaks as he pleased and

work as many days each week as he desired as long as he completed the project on time.

28. Claimant was not required to work exclusively for GMD. He actually and customarily provided drywall-finishing services to others. During the time Claimant worked for GMD he performed similar services for at least one other subcontractor. The credible testimony of G. Montanez reveals that during the period Claimant worked for him, Claimant continued to work for Mr. Salgado and others in Denver, Colorado Springs, and Pueblo. On several occasions G. Montanez checked on houses that he had subcontracted to Claimant for drywall finishing but Claimant and his crew were not at the houses. G. Montanez specifically noted that, shortly before Claimant began working on the house where he was injured, he performed work for Mr. Salgado on a house on Old Ranch Road in Colorado Springs. There were also several times when Mr. Kirk stopped by houses where Claimant was supposed to be working, but Claimant was not present. The evidence also reveals that during the two-year period preceding his work injury Claimant moved from one contractor to the next when work slowed down or when a subsequent contractor could offer him more steady work.

29. Balancing the factors enumerated in §8-40-202(2)(a), C.R.S. reflects that GMD has established that it is more probably true than not that Claimant worked as an independent contractor.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Pursuant to §8-40-202(2)(a), C.R.S. "any individual who performs services for pay for another shall be deemed to be an employee" unless the person "is free from control and direction in the performance of the services, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent . . . business related to the service performed." The "employer" may establish that the worker is an independent contractor by proving the presence of some or all of the nine criteria enumerated in §8-40-202(2)(b)(II), C.R.S. *See Nelson v. ICAO,* 981 P.2d 210, 212 (Colo. App. 1998). The factors in §8-40-202(2)(b)(II), C.R.S. suggesting that a person is not an independent contractor include whether the person is paid a salary or hourly wage rather than a fixed contract rate and whether the person is paid individually rather than under a trade or business name. Conversely, independence may be shown if the "employer" provides only minimal training for the worker, does not dictate the time of performance, does not establish a quality standard for the work performed, does not combine its business with the business of the worker, does not require the worker to work exclusively for a single entity, and is unable to terminate the worker's employment without liability. *In Re of Salgado-Nunez,* W.C. No. 4-632-020 (ICAP, June 23, 2006). Section 8-40-202(b)(II) creates a "balancing test" to ascertain whether an "employer" has overcome the presumption of employment in §8-40-202(2)(a), C.R.S. The question of whether the "employer" has presented sufficient proof to overcome the presumption is one of fact for the Judge. *Id.*

5. To be customarily engaged in an independent business, the worker must "actually and customarily provide similar services to others at the same time he or she works for the putative employer." *Carpet Exchange v. ICAO,* 859 P.2d 278, 282 (Colo. App. 1993). However, performance of similar services to others regarding the independent trade need not be contemporaneous in cases involving short-term contracts for services. *Long View Systems Corp. USA v. ICAO,* 197 P.3d 295, 299-300 (Colo. App. 2008).

6. As found, GMD has demonstrated by a preponderance of the evidence that Claimant worked for it as an independent contractor and that he was free from direction and control in the performance of his drywall-finishing duties.

7. As found, two factors weigh against concluding that Claimant worked as an independent contractor for GMD. First, Claimant received personal checks from GMD because he did not have a trade name. Claimant then divided the checks with other members of his work crew. Furthermore, GMD has failed

to produce sufficient evidence that it could terminate its relationship with Claimant without liability.

8. As found, the overwhelming majority of factors suggest that Claimant worked as an independent contractor for GMD. Initially, GMD did not combine its business with Claimant's business. Moreover, during the time that Claimant performed work for GMD he used his own work van and supplied his own tools. Moreover, although GMD supplied Claimant with a taping bazooka, Claimant was required to rent the machine from GMD. Renting a piece of equipment to an individual is not consistent with an employer-employee relationship.

9. As found, GMD did not provide any training to Claimant regarding drywall-finishing work and Claimant required little supervision. Claimant had significant drywall experience and was a skilled drywall finisher.

10. As found, GMD did not dictate a quality standard for Claimant's work. Although G. Montanez and Mr. Kirk ensured that Claimant's work satisfied contract and builder specifications, they did not oversee Claimant's actual work or instruct Claimant on proper drywall finishing.

11. As found, GMD paid Claimant by the sheet of drywall that he finished. Claimant did not receive an hourly rate for his work.

12. As found, GMD did not dictate the time of performance for Claimant's drywall finishing. GMD provided Claimant with a texture or completion date. The texture or completion date is the date on which the builder has mandated completion of the drywall phase of the house. Claimant was thus not required to work a fixed schedule. He was permitted to set his own hours, take breaks as he pleased and work as many days each week as he desired as long as he completed the project on time.

13. As found, Claimant was not required to work exclusively for GMD. He actually and customarily provided drywall-finishing services to others. During the time Claimant worked for GMD he performed similar services for at least one other subcontractor. The credible testimony of G. Montanez reveals that during the period Claimant worked for him, Claimant continued to work for Mr. Salgado and others in Denver, Colorado Springs, and Pueblo. On several occasions G. Montanez checked on houses that he had subcontracted to Claimant for drywall finishing but Claimant and his crew were not at the houses. G. Montanez specifically noted that, shortly before Claimant began working on the house where he was injured, he performed work for Mr. Salgado on a house on Old Ranch Road in Colorado Springs. There were also several times when Mr. Kirk stopped by houses where Claimant was supposed to be working, but Claimant was not present. The evidence also reveals that during the two-year period preceding his work injury Claimant moved from one contractor to the next when

work slowed down or when a subsequent contractor could offer him more steady work.

14. As found, balancing the factors enumerated in §8-40-202(2)(a), C.R.S. reflects that GMD has established by a preponderance of the evidence that Claimant worked as an independent contractor.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant worked as an independent contractor for GMD pursuant to §8-40-202(2) C.R.S. Specifically, Claimant actually and customarily provided similar drywall-finishing services to others. Therefore, his request for Workers' Compensation benefits is denied and dismissed.

DATED: July 31, 2009.

Peter J. Cannici
Administrative Law Judge